State of New Hampshire
Department of Health and Human Services

REQUEST FOR PROPOSALS [RFP-2016-OQAI-01-PREMI]

FOR

Premium Assistance Program Evaluation Plan Implementation

March 31, 2016

Table of Contents

1. INTRODUCTION

1.1. Overview

The New Hampshire Department of Health and Human Services (DHHS), Office of Quality Assurance and Improvement (OQAI) is seeking competitive proposals, from responsible and qualified Bidders, for the implementation of the Premium Assistance Program Evaluation Plan found in Appendix F. The evaluation is a required element of the Department of Health and Human Services' New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration, Section 1115 Medicaid Demonstration Waiver, #11-W-00298/1.

To qualify, Bidders must have experience in evaluating Section 1115 Medicaid Waiver projects, and must either be a National Committee for Quality Assurance certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor or shall sub-contract with a certified vendor.

1.2. Purpose

On March 4, 2015, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's application for a three-year Section 1115 demonstration project titled, "New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration." Under the project, the majority of NHHPP beneficiaries began receiving their Medicaid benefits through a Premium Assistance Program (PAP) on January 1, 2016.

As part of the approved application to receive a Section 1115 Medicaid Demonstration Waiver, DHHS submitted and received approval from CMS of an evaluation plan to determine if the PAP is meeting the goals of:

- Continuity of coverage;
- Plan Variety;
- Cost-effective coverage; and
- Uniform provider access.

This RFP and the resultant contract incorporate the CMS approved evaluation plan; the successful Contractor will be required to conduct an evaluation of the PAP in accordance with this plan.

1.3. Request for Proposal Terminology

ABP – Alternative Benefit Plan

CFDA – Catalog of Federal Domestic Assistance

CMS – Centers for Medicare and Medicaid Services

DHHS – Department of Health and Human Services

RFP – Request for Proposals. A Request for Proposals means an invitation to submit a proposal to provide specified goods or services, where the particulars of the goods or services and the price are proposed by the vendor and, for proposals meeting or exceeding specifications, selection is according to identified criteria as provided by RSA 21-I:22-a and RSA 21-I:22-b.

NHHPP – New Hampshire Health Protection Program

QHP – Qualified Health Plan

PAP – Premium Assistance Program

1.4. Contract Period

The Contract resulting from this RFP will be effective July 1, 2016 or upon Governor and Executive Council approval, whichever is later, through December 31, 2019.

The Department may extend the contract for up to one (1) additional year at the sole discretion of the Department, considering Contractor performance, and contingent upon the continuation of the NHHPP by the NH General Court, continued funding, and Governor and Executive Council approval.

2. BACKGROUND AND REQUIRED SERVICES

2.1. New Hampshire Health Protection Program

In 2014, the New Hampshire Legislature passed Senate Bill 413 which authorized the New Hampshire Health Protection Program (NHHPP) to expand Medicaid to Adults age 19 to 64. Coverage began in August of the same year and, as of March 1, 2016, the NHHPP was providing coverage to over 49,000 beneficiaries**.**

The enabling legislation required that nearly all beneficiaries would first be covered under the State's existing Medicaid managed care program and then transitioned on January 1, 2016 to a Premium Assistance Program, wherein Medicaid funds would be used to purchase private coverage on the health insurance marketplace and the Medicaid program would provide wrap-around services as needed.

2.2. NHHPP - Premium Assistance Program

Under the authority granted through the Section 1115 waiver, beginning January 1, 2016, non-medically frail NHHPP beneficiaries transitioned to the State's Premium Assistance Program (PAP). Under the PAP program, beneficiaries receive premium assistance to purchase health coverage from Qualified Health Plans (QHPs) in the health insurance marketplace. Any benefit that QHPs do not cover, that are included in the State's approved alternative benefit plan for the NHHPP population, are covered by NH Medicaid (e.g. Non-emergency medical transportation, vision, and limited dental). As of March 1, 2016, over 38,000 beneficiaries were receiving benefits through the PAP program.

The goals of the PAP Demonstration Project are:

- Continuity of coverage – for individuals whose incomes fluctuate above the NHHPP income limits or through gaining or losing employer sponsored insurance, the PAP Demonstration will permit continuity of health plans and provider networks;

- Plan variety – the PAP Demonstration will encourage Medicaid Care Management carriers to offer QHPs in the Marketplace, in order to retain Medicaid market share, and will encourage QHP carriers to seek Medicaid managed care contracts (currently one Medicaid Care Management plan also operates as a QHP);
- Cost-effective coverage – the premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs; and
- Uniform provider access – beneficiaries in the PAP Demonstration will receive comparable access to primary, specialty, and behavioral health care services as the access afforded to the general population in New Hampshire.

2.3. Premium Assistance Program Evaluation

DHHS' CMS-approved NHHPP PAP Demonstration Waiver Evaluation Plan is built on monitoring both process and outcome performance measures that increase in number over the three years potentially available for the waiver due to data varying in collection, processing, and finalization cycles. This increase in available evaluation data over time means that the data available towards the end of 2016 (i.e., first year of the NHHPP PAP) will not be complete and should be considered a first approximation for the first set of monitoring measures, rather than definitive results.

The core purpose of the Evaluation Plan is to determine the costs and effectiveness of the NHHPP PAP, when considered in its totality, and taking into account both initial and longer term costs and other impacts, such as improvements in service delivery and health outcomes. The evaluation will explore and explain the effectiveness of the Demonstration by addressing a range of hypotheses that connect to the goals of the project.

Included in the evaluation will be examinations of NHHPP PAP performance on a set of access and clinical quality measures against a comparable population in the New Hampshire Medicaid Care Management Program. The State will also compare costs (i.e., total, administrative, and medical) under the Demonstration to costs under the Medicaid Care Management Program.

The results of the evaluation will be prepared and report results compared to the goals of the program. A series of reports with varying periodicities will be provided to CMS in alignment with the Special Terms and Conditions of the approval of NH's Section 1115 Demonstration, entitled "New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration." The Special Terms and Conditions can be found in Appendix E.

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3. STATEMENT OF WORK

3.1. Covered Populations and Services

The study population consists of all beneficiaries covered under Title XIX of the Social Security Act in the state of New Hampshire, from 19 years through 64 years of age who are not medically frail, incarcerated, or enrolled in cost-effective employer sponsored insurance.

3.2. Scope of Services

3.2.1. Conduct Evaluation

3.2.1.1. The Contractor shall conduct an evaluation of the NHHPP PAP utilizing the the CMS-approved Evaluation Plan found in Appendix F. The Contractor shall ensure that all activities described in the Evaluation Plan shall be conducted by the Contractor in compliance with the Evaluation Plan.

3.2.1.2. The Contractor shall support DHHS in complying with CMS General Reporting, Evaluation, and Monitoring requirements, as outlined in the Special Terms and Conditions (STC), found in Appendix E, of the CMS approval of NH's Section 1115 Demonstration, entitled "New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration."[1]

Q1. Describe in detail the Bidder's experience, expertise, and knowledge in evaluating publicly-funded health care services and programs, including the Bidder's understanding and experience as applied to Medicaid 1115 waivers. Specifically, the description must address the Bidder's experience in:

- Performing quantitative and qualitative evaluation of large-scale public assistance programs;
- Analyzing Medicaid program administrative data, including enrollment, provider, cost and service utilization data;
- Performance measure calculation and analysis;
- Actuarially assessing waiver budget cost neutrality; and
- General understanding of Federal and state Medicaid policy, and specific understanding of policy changes related to the NH Health Protection Program and the Federal Affordable Care Act.

Q2. Bidders must provide proof of conducting a minimum of two (2) Medicaid 1115 waiver or similar evaluation projects performed for private, state or large local government clients within the last five years. The Bidder shall include, at minimum:

- Name, address, telephone number, and website of the customer;
- A description of the work performed under each contract;
- A description of the nature of the relationship between the Bidder and the customer;
- Name, telephone number, and e-mail address of the person whom DHHS can contact as a reference; and

[1] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf

- Dates of performance.

3.2.2. Data Sources and Collection.

DHHS will provide the Contractor with data from the following sources to perform the evaluation. The Contractor shall work with DHHS to assure that appropriate data use agreements are in place to obtain these data. The Contractor shall be expected to review, analyze, and organize these data. The Contractor shall ensure the secure storage of the DHHS-provided data, and Secure File Transfer Protocols shall be followed in the transfer of data. The Contractor shall ensure all data, and any copies thereof, is returned to DHHS upon DHHS request, or no later than contract expiration, whichever occurs first, unless otherwise instructed by DHHS to destroy copied data. Data format shall comply with that described in the Evaluation Plan:

3.2.2.1. New Hampshire's Comprehensive Health Care Information System (CHIS), NH's all payer claims database—commercial data and QHP data;

3.2.2.2. New Hampshire's Medicaid Management Information System (MMIS)—fee for service and MCO encounter data;

3.2.2.3. All-payer Hospital Data;

3.2.2.4. New Hampshire Medicaid financial data;

3.2.2.5. CAHPS results for the baseline of newly eligible members of the Bridge Program, provided by DHHS. All other CAHPS survey results required for the evaluation shall be collected by the Contractor using a CAHPS certified vendor.

Q3. Describe the bidder's approach to obtaining, reviewing, storing and analyzing the data sources described in the evaluation plan for the first,1-year PAP Demonstration Waiver. Description must include any specific software and subcontractors that will be utilized. Bidders must highlight any differences in their approach for a 3-year PAP Demonstration Waiver.

Q4. Please describe the Bidder's process to receive and protect the data, and the process the Bidder intends to utilize to ensure the data is destroyed when the contract expires.

3.2.3. Measure Calculation

The Contractor shall calculate all measures in the Evaluation Plan. Calculations shall utilize all analytical methods outlined in the Evaluation Plan with a rigor meeting research standards of leading academic institutions and academic journal peer review.

3.2.3.1. As part of measure calculation the Contractor shall administer two CAHPS surveys in the first part of 2017 and 2018 harmonized with the timeframes of Medicaid Managed Care Organization CAHPS surveys. The CAHPS survey shall include questions necessary for the evaluation.

Q5. Describe the Bidder's approach to calculating the performance measures in the Evaluation Plan for the first, 1-year PAP Demonstration Waiver. Response must include the Bidder's approach to using all analytical methods outlined in the Evaluation Plan, including the approach to required CAHPS surveys. Bidders must highlight any differences that will change and/or be adopted in their approach for the 3-year PAP Demonstration Waiver evaluation.

3.2.4. Reporting

The Contractor shall prepare and deliver the following reports to DHHS according to the schedule found in Exhibit F:

3.2.4.1. **Quarterly Reports for CMS –** The Contractor shall report quarterly on the progress of evaluation activities, including key milestones accomplished, challenges encountered with detail on how challenges were resolved, and any opportunities for improvement. The Contractor shall include interim quantitative findings when available. The Contractor shall submit quarterly report drafts no less than two calendar weeks prior to the CMS deadline for DHHS review. The first quarterly report the Contractor will be responsible for is for the July to September 2016 period;

3.2.4.2. **Annual Reports for CMS –** The Contractor shall report annually on the progress of evaluation activities, challenges encountered with detail on how challenges were resolved, and any opportunities for improvement. The Contractor shall include interim findings when available. The Contractor shall submit a draft of the annual report to DHHS no less than thirty (30) calendar days prior to the CMS deadline;

3.2.4.3. **Rapid Cycle Reports to CMS –** The Contractor shall develop a rapid cycle reporting consistent with the Evaluation Plan. Two (2) months prior to the CMS deadline, the Contractor shall submit to DHHS an outline of the report, and no less than thirty (30) calendar days prior to the CMS deadline, the Contractor shall submit to DHHS a draft of the report;

3.2.4.4. **Interim Evaluation Report for CMS –** The Contractor shall develop an interim evaluation report consistent with the Evaluation Plan. The Contractor shall submit a detailed outline of this report to DHHS at least six (6) months prior to the CMS deadline. The Contractor shall submit the first draft of the report to DHHS no less than three (3) months prior to the CMS deadline;

3.2.4.5. **Preliminary Evaluation Report for CMS –** The Contractor shall develop a preliminary evaluation report consistent with the Evaluation Plan. The Contractor shall submit to DHHS a detailed outline of this report at least six (6) months prior to the CMS deadline. The Contractor shall submit the first draft of the report to DHHS no less than three (3) months prior to the CMS deadline;

3.2.4.6. **Final Evaluation Report for CMS –** The Contractor shall develop a final evaluation report that follows the Evaluation Plan. The Contractor shall submit the first draft of the report to DHHS no less than three (3) months prior to the CMS deadline;

3.2.4.7. **CMS Comments –** DHHS will provide CMS comments to the Contractor. The Contractor shall provide drafts to DHHS in response to CMS comments on all reports no less than fifteen (15) calendar days prior to the CMS deadline for responses;

3.2.4.8. **Analytic and Summary Data Files –** The Contractor shall provide DHHS with its summary and analytic data files used to conduct the evaluation upon request. These files shall be organized, clearly labeled, and accompanied by a data dictionary; and

3.2.4.9. **CMS Presentations –** The Contractor, in coordination with DHHS, shall present the interim, summative and all other requested evaluation reports to CMS during the timeframes of the contract. DHHS will notify the Contractor of CMS requests for presentations.

Q6. Describe the Bidder's approach to completing the reporting outlined in this RFP for the first, 1-year PAP Demonstration Waiver. Bidders must highlight any differences in their approach for the 3-year PAP Demonstration Waiver.

3.2.5. Project Management and Support

3.2.5.1. The Contractor shall provide a work plan, no later than 30 calendar days after the beginning of the contract. The work plan shall address all activities in the contract including:

a. All related and accompanying tasks;
b. Timeframes for completion; and
c. Identification of the responsible party (i.e., DHHS or the Contractor);

3.2.5.2. The Contractor shall host weekly conference calls with DHHS staff throughout the project. Upon mutual agreement of the parties, more or less frequent calls may be scheduled.

3.2.5.3. The Contractor shall participate in conference calls with CMS as needed.

3.2.5.4. The Contractor shall provide written monthly progress status reports to DHHS, including but not limited to: accomplishments, tasks currently being addressed, open issues, updated decision log.

3.2.5.5. The Contractor shall respond,via email, to all inquiries from DHHS in no later than two (2) business days.

Q7. Bidders must provide a timeline of milestones for the completion of project deliverables and the tasks necessary to accomplish each deliverable, including review of data, analysis, and final reporting for the first, 1-year PAP Demonstration Waiver.

Q8. Bidders must provide a timeline of milestones for the completion of project deliverables and the tasks necessary to accomplish each deliverable, including review of data, analysis, and final reporting for a final, 3-year PAP Demonstration Waiver.

3.3. Staffing

3.3.1. Minimum Staffing Requirements

3.3.1.1. The Contractor shall provide adequate numbers of professionally qualified staff to perform all required contracted services. The Contractor shall guarantee that all personnel providing the services required by the Contract are qualified to perform their assigned tasks and possess the appropriate professional certification and licensing that may be required by state and federal laws, rules and regulations;

3.3.1.2. DHHS shall be advised of, and approve in writing, any permanent or temporary changes to or deletions from the Contractor's management, supervisory, and key professional personnel, who directly impact the provision of required services;

3.3.1.3. Contractor shall ensure that it has qualified staff to conduct all contracted activities, and shall assign the following personnel, at minimum for the duration of this Agreement:

a. Project Manager to oversee all of the activities of the contract with DHHS, to oversee and fulfill the requirements in subsection 3.2.5. Project Management and Support, and to be the primary point of contact for all DHHS inquiries and requests for responsive action;
b. Technical staff to provide oversight and expertise with information technology systems and processes;
c. Actuarial staff to produce the cost neutrality evaluation; and
d. Reporting staff to compile, prepare and draft technical reports for publication in accordance with the terms of this agreement; and
e. Staff to manage and develop work plans for all reports required under this agreement (this responsibility may be incorporated into one or more positions referenced above if not otherwise separately allocated).

Q9. Provide a description of key staff that will conduct and manage the program evaluation. Include a description of staff roles related to the evaluation, staff qualifications and relevant experience, and complete Appendix C, Project Staff List. Biographies or curriculum vitae for all key staff must be provided.

3.4. Delegation and Subcontractors

3.4.1. Identification and Approval

3.4.1.1. The Contractor shall identify any and all subcontractors to be utilized in fulfillment of its contractual responsibilities. DHHS reserves the right to accept or reject the use of any subcontractor.

Q10. Describe in detail the subcontractors the Bidder proposes to utilize (if any) in support of meeting the contractual requirements described in this RFP, including at minimum identifying the subcontractors, providing the contact information for the subcontractors, and identifying past experience working with the subcontractors.

3.5. Compliance with State and Federal Laws

3.5.1. General

3.5.1.1. The Contractor, its subcontractors, and any other providers with which they have Agreements with, shall adhere to all applicable federal and State laws, including subsequent revisions, whether or not included in this subsection [42 CFR 438.6; 42 CFR 438.100(a)(2); 42 CFR 438.100(d)].

3.5.1.2. The Contractor shall ensure that safeguards at a minimum equal to federal safeguards (41 USC 423, section 27) are in place, providing safeguards against conflict of interest [§1923(d)(3) of the SSA; SMD letter 12/30/97].

3.5.1.3. The Contractor shall comply with the following Federal and State Medicaid Statutes, Regulations, and Policies:

a. Medicare: Title XVIII of the Social Security Act, as amended; 42 U.S.C.A. §1395 et seq.;
b. Related rules: Title 42 Chapter IV;
c. Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. §1396 et seq. (specific to managed care: §§ 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA);
d. Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR § 438; see also 431 and 435);
e. Children's Health Insurance Program (CHIP): Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397;
f. Regulations promulgated thereunder: 42 CFR 457;
g. Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57;
h. Patient Protection and Affordable Care Act of 2010;
i. Health Care and Education Reconciliation Act of 2010, amending the Patient Protection and Affordable Care;
j. State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26;
k. American Recovery and Reinvestment Act; and
l. All other relevant federal and state regulation.

3.5.1.4. The Contractor shall not release and make public statements or press releases concerning the program without the prior consent of DHHS.

3.5.1.5. The Contractor shall comply with the Health Insurance Portability & Accountability Act of 1996 (between the State and the Contractor, as governed by 45 C.F.R. Section 164.504(e)). Terms of the Agreement shall be considered binding upon execution of this Agreement, shall remain in effect during the term of the Agreement including any extensions, and its obligations shall survive the Agreement.

4. FINANCE

4.1. Financial Standards

4.1.1. Finance Funding Sources

4.1.1.1. Funds to support the services solicited in this RFP are available from two funding sources, identified as follows:

a. 50% Federal Funds from the Centers for Medicare and Medicaid Services, Department of Health and Human Services, Medical Assistance Program, CFDA #93.778; and
b. 50% General Funds

4.1.1.2. Funds must be used in accordance with the provisions of the CFDA numbers referenced in 4.1.1.1.; and in accordance with the Standard Terms and Conditions for the New Hampshire Health Protection Program (NHHPP) Premium Assistance Demonstration, Section 1115 Medicaid Demonstration Waiver, #11-W-00298/1.

4.1.2. Budget

4.1.2.1. The Contractor shall provide services under this contract based on an agreed upon Budget. The contract shall be a firm, fixed price contract, that reimburses the Contractor for expenses incurred in the fulfillment of the contract in accordance with the agreed upon budget.

NOTE: Bidders must submit separate proposed budgets for the first, 1-year PAP Demonstration Waiver, and the final, 3-year PAP. The final, negotiated budget(s) will be formally incorporated into the contract and binding upon the parties; any amendments thereto will require a written agreement by the parties in the form of a contract amendment, which may be subject to Governor and Executive Council approval and at minimum shall be subject to Attorney General approval.

4.1.2.2. Budgets must contain, at minimum, the following budgetary lines: salaries/wages, travel, subcontractors, other, and indirect costs.

NOTE: Bidders must include a Budget Narrative in the Cost Proposal. The Budget Narrative must provide justification for the proposed costs, by line item, in the budget(s).

4.1.3. Invoicing

4.1.3.1. The Contractor shall invoice DHHS monthly for services performed in accordance with the contract. The Contractor shall ensure DHHS receives the applicable invoice within thirty (30) days following the end of the month in which services were provided.

4.1.4. Financial Management

4.1.4.1. The Contractor shall designate a contact person to resolve any questions or discrepancies regarding invoices. The Contractor shall provide DHHS with the name, title, telephone number, fax number and email address of the contact person. The Contractor shall also notify DHHS in the event of a change of the designated contact person.

4.1.4.2. DHHS shall provide the Contractor with the name, title, mailing address, and telephone number of the corresponding DHHS contact person. DHHS shall notify the Contractor in the event of a change in the designated contact person.

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5. PROPOSAL EVALUATION

5.1. Technical Proposal – 300 points

5.1.1. Proposal Narrative, Project Approach and Technical Response

Questions to be Scored	Maximum Points Available
Bidder's Experience (Q1-Q2)	50
Data Sources and Collection (Q3-Q4)	50
Measurement Calculation (Q5)	50
Reporting (Q6)	50
Project Management and Support (Q7-Q8)	50
Staffing and Subcontracting (Q9-Q10)	50
Total	300

5.2. Cost Proposal – 200 points

Item	Maximum Points Available
Budget	150
Budget Narrative	50
Total	200

6. PROPOSAL PROCESS

6.1. Contact Information – Sole Point of Contact

The sole point of contact, the Procurement Coordinator, relative to the bid or bidding process for this RFP, from the RFP issue date until the selection of a Bidder, and approval of the resulting contract by the Governor and Executive Council is:

State of New Hampshire
Department of Health and Human Services
Diana Lacey
Contract Specialist
Brown Building
129 Pleasant St.
Concord, New Hampshire 03301
Email: diana.lacey@dhhs.state.nh.us
Fax: 603-271-4232
Phone: 603-271-9285

Other personnel are NOT authorized to discuss this RFP with Bidders before the proposal submission deadline. Contact regarding this RFP with any State personnel not listed above could result in disqualification. The State will not be held responsible for oral responses to Bidders regardless of the source.

6.2. Procurement Timetable

Procurement Timetable (All times are according to Eastern Time. DHHS reserves the right to modify these dates at its sole discretion.)		
Item	Action	Date
1.	Release RFP	3/31/16
2.	Optional Letter of Intent Submission Deadline	04/11/16
3.	RFP Bidders Question and Answer Period	04/01/16-04/14/16
4.	DHHS Response to Questions Published	04/18/16
5.	Technical and Cost Bids Submission Deadline	04/28/16 @ 4:00 PM
6.	Anticipated Selection of Successful Bidder(s)	05/04/16

6.3. Letter of Intent

A Letter of Intent to submit a Proposal in response to this RFP is optional. Receipt of the Letter of Intent by DHHS will be required in order to directly receive any correspondence regarding this RFP, any RFP amendments, in the event such are produced, or any further materials on this project, including electronic files containing tables required for response to this RFP, any addenda, corrections, schedule modifications, or notifications regarding any informational meetings for Bidders, or responses to comments or questions.

The Letter of Intent may be transmitted by e-mail to the Procurement Coordinator identified in Section 6.1. The potential Bidder is responsible for successful e-mail transmission. DHHS will provide confirmation of receipt of the Letter of Intent if the name and e-mail address or fax number of the person to receive such confirmation is provided by the Bidder.

The Letter of Intent must include the name, telephone number, mailing address and e-mail address of the Bidder's designated contact to which DHHS will direct RFP related correspondence.

6.4. Bidders' Questions and Answers

6.4.1. Bidders' Questions

All questions about this RFP, including but not limited to requests for clarification, additional information or any changes to the RFP must be made in writing, citing the RFP page number and part or subpart, and submitted to the Procurement Coordinator identified in Section 6.1.

DHHS may consolidate or paraphrase questions for efficiency and clarity. Questions that are not understood will not be answered. Statements that are not questions will not receive a response.

Questions will only be accepted within the period given in Section 6.2, Procurement Timetable. DHHS will not acknowledge receipt of questions.

The questions may be submitted by fax or e-mail; however, DHHS assumes no liability for assuring accurate and complete fax and e-mail transmissions.

Questions must be received by DHHS by the deadline given in Section 6.2, Procurement Timetable.

6.4.2. Bidders' Conferences

6.4.2.1. Technical Proposal Conference

A Technical Proposal Conference is not being held for this procurement.

6.4.2.2. Cost Proposal Conference

A Cost Proposal Conference is not being held for this procurement.

6.4.3. DHHS Answers

DHHS intends to issue responses to properly submitted questions by the deadline specified in Section 6.2, Procurement Timetable. Written answers to questions asked will be posted on the DHHS Public website (http://www.dhhs.nh.gov/business/rfp/index.htm) and sent as an attachment in an e-mail to the contact identified in accepted Letters of Intent. This date may be subject to change at DHHS discretion.

6.5. RFP Amendment

DHHS reserves the right to amend this RFP, as it deems appropriate prior to the Proposal Submission Deadline on its own initiative or in response to issues raised through Bidder questions. In the event of an amendment to the RFP, DHHS, at its sole discretion, may extend the Proposal Submission Deadline. Bidders who submitted a Letter of Intent will receive notification of the amendment, and the amended language will be posted on the DHHS Internet site.

6.6. Proposal Submission

Proposals submitted in response to this RFP must be received no later than the time and date specified in Section 6.2, Procurement Timetable. Proposals must be addressed for delivery to the Procurement Coordinator specified in Section 6.1, and marked with **RFP-2016-OQAI-01-PREMI**.

Late submissions will not be accepted and will remain unopened. Disqualified submissions will be discarded if not re-claimed by the bidding Bidder by the time the contract is awarded. Delivery of the Proposals shall be at the Bidder's expense. The time of receipt shall be considered when a Proposal has been officially documented by DHHS, in accordance with its established policies, as having been received at the location designated above. The State accepts no responsibility for mislabeled mail. Any and all damage that may occur due to shipping shall be the Bidder's responsibility.

6.7. Compliance

Bidders must be in compliance with applicable federal and state laws, rules and regulations, and applicable policies and procedures adopted by the Department of Health and Human Services currently in effect, and as they may be adopted or amended during the contract period.

6.8. Non-Collusion

The Bidder's required signature on the Transmittal Cover Letter for a Proposal submitted in response to this RFP guarantees that the prices, terms and conditions, and services quoted have been established without collusion with other Bidders and without effort to preclude DHHS from obtaining the best possible competitive proposal.

6.9. Collaborative Proposals

Proposals must be submitted by one organization. Any collaborating organization must be designated as subcontractor subject to the terms of Exhibit C Special Provisions (see Appendix B: Contract Minimum Requirements).

6.10. Validity of Proposals

Proposals submitted in response to this RFP must be valid for two hundred forty (240) days following the Technical and Cost Proposal Submission Deadline specified in Section 6.2, Procurement Timetable or until the effective date of any resulting contract, whichever is later. This period may be extended by mutual written agreement between the Bidder and DHHS.

6.11. Property of Department

All material property submitted and received in response to this RFP will become the property of DHHS and will not be returned to the Bidder. DHHS reserves the right to use any information presented in any Proposal provided that its use does not violate any copyrights or other provisions of law.

6.12. Proposal Withdrawal

Prior to the Technical and Cost Proposal Submission Deadline specified in Section 6.2, Procurement Timetable, a submitted Letter of Intent or Proposal may be withdrawn by submitting a written request for its withdrawal to the Procurement Coordinator specified in Section 6.1.

6.13. Public Disclosure

A Proposal must remain confidential until the Governor and Executive Council have approved a contract as a result of this RFP. A Bidder's disclosure or distribution of Proposals other than to the State will be grounds for disqualification.

The content of each Bidder's Proposal, and addenda thereto, will become public information once the Governor and Executive Council have approved a contract. Any information submitted as part of a bid in response to this RFP may be subject to public disclosure under RSA 91-A. In addition, in accordance with RSA 9-F:1, any contract entered into as a result of this RFP will be made accessible to the public online via the website Transparent NH (www.nh.gov/transparentnh/). Accordingly, business financial information and proprietary information such as trade secrets, business and financials models and forecasts, and proprietary formulas may be exempt from public disclosure under RSA 91-A:5, IV.

Insofar as a Bidder seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the Bidder must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. This should be done by separate letter identifying by page number and proposal section number the specific information the Bidder claims to be exempt from public disclosure pursuant to RSA 91-A:5.

Each Bidder acknowledges that DHHS is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. DHHS shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event DHHS receives a request for the information identified by a Bidder as confidential, DHHS shall notify the Bidder and specify the date DHHS intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the Bidder's responsibility and at the Bidder's sole expense. If the Bidder fails to obtain a court order enjoining the disclosure, DHHS may release the information on the date DHHS specified in its notice to the Bidder without incurring any liability to the Bidder.

6.14. Non-Commitment

Notwithstanding any other provision of this RFP, this RFP does not commit DHHS to award a contract. DHHS reserves the right to reject any and all Proposals or any portions thereof, at any time and to cancel this RFP and to solicit new Proposals under a new bid process.

6.15. Liability

By submitting a Letter of Intent to submit a Proposal in response to this RFP, a Bidder agrees that in no event shall the State be either responsible for or held liable for any costs incurred by a Bidder in the preparation or submittal of or otherwise in connection with a Proposal, or for work performed prior to the Effective Date of a resulting contract.

6.16. Request for Additional Information or Materials

During the period from the Technical and Cost Proposal Submission Deadline, specified in Section 6.2, Procurement Timeline, to the date of Contractor selection, DHHS may request of any Bidder additional information or materials needed to clarify information presented in the Proposal. Such a request will be issued in writing and will not provide a Bidder with an opportunity to change, extend, or otherwise amend its Proposal in intent or substance. Key personnel shall be available for interviews.

6.17. Oral Presentations and Discussions

No oral presentations or discussions with Bidders will be conducted prior to the Department’s selection of the successful Bidder(s).

6.18. Contract Negotiations and Unsuccessful Bidder Notice

If a Bidder(s) is selected, the State will notify the Successful Bidder(s) in writing of their selection and the State’s desire to enter into contract negotiations. Until the State successfully completes negotiations with the selected Bidder(s), all submitted Proposals remain eligible for selection by the State. In the event contract negotiations are unsuccessful with the selected Bidder(s), the evaluation team may recommend another Bidder(s).

In order to protect the integrity of the bidding process, notwithstanding RSA 91-A:4, no information shall be available to the public, or to the members of the general court or its staff, concerning specific responses to requests for bids (RFBs), requests for proposals (RFPs), requests for applications (RFAs), or similar requests for submission for the purpose of procuring goods or services or awarding contracts from the time the request is made public until the closing date for responses except that information specifically allowed by RSA 21-G:37.

6.19. Scope of Award and Contract Award Notice

DHHS reserves the right to award a service, part of a service, group of services, or total Proposal and to reject any and all Proposals in whole or in part. The notice of the intended contract award will be sent by certified mail or overnight mail to the selected Bidder. A contract award is contingent on approval by the Governor and Executive Council.

If a contract is awarded, the Bidder must obtain written consent from the State before any public announcement or news release is issued pertaining to any contract award.

6.20. Site Visits

DHHS reserves the right to request a site visit for DHHS staff to review a Bidder's organization structure, subcontractors, policy and procedures, and any other aspect of the Proposal that directly affects the provisions of the RFP and the delivery of services. Any and all costs associated with the site visits incurred by the Bidder shall be borne by the Bidder.

Prior to implementation, DHHS reserves the right to make a pre-delegation audit by DHHS staff to the Bidder's site to determine that the Bidder is prepared to initiate required activities. Any and all costs associated with this pre-delegation visit shall be borne by the Bidder.

6.21. Protest of Intended Award

Any protests of intended award or otherwise related to the RFP, shall be governed by the appropriate State requirements and procedures and the terms of this RFP. In the event that a legal action is brought challenging the RFP and selection process, and in the event that the State of New Hampshire prevails, the Bidder agrees to pay all expenses of such action, including attorney's fees and costs at all stages of litigations. Legal action shall include administrative proceedings.

6.22. Contingency

Aspects of the award may be contingent upon changes to State or federal laws and regulations.

7. PROPOSAL OUTLINE AND REQUIREMENTS

7.1. Presentation and Identification

7.1.1. Overview

7.1.1.1. Bidders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal are at the Bidder's risk and may, at the discretion of the State, result in disqualification.

7.1.1.2. Proposals must conform to all instructions, conditions, and requirements included in the RFP.

7.1.1.3. Acceptable Proposals must offer all services identified in Section 3 - Statement of Work, unless an allowance for partial scope is specifically described in Section 3, and agree to the contract conditions specified throughout the RFP.

7.1.1.4. Proposals should be received by the Technical and Cost Proposal Submission Deadline specified in Section 6.2, Procurement Timetable, and delivered, under sealed cover, to the Procurement Coordinator specified in Section 6.1.

7.1.1.5. Fax or email copies will not be accepted.

7.1.1.6. Bidders shall submit a Technical Proposal and a Cost Proposal.

7.1.2. Presentation

7.1.2.1. Original copies of Technical and Cost Proposals in separate three-ring binders.

7.1.2.2. Copies in a bound format (for example wire bound, coil bound, saddle stitch, perfect bound etc. at minimum stapled) NOTE: loose Proposals will not be accepted.

7.1.2.3. Major sections of the Proposal separated by tabs.

7.1.2.4. Standard eight and one-half by eleven inch (8 ½" x 11") white paper.

7.1.2.5. Font size of 10 or larger.

7.1.3. Technical Proposal

7.1.3.1. Original in 3 ring binder marked as "Original."

7.1.3.2. The original Transmittal Letter (described in Section 7.2.2.1) must be the first page of the Technical Proposal and marked as "Original."

7.1.3.3. 4 copies in bound format marked as "Copy."

7.1.3.4. 1 electronic copy (divided into folders that correspond to and are labeled the same as the hard copies) on CD or Memory Card/Thumb Drive. NOTE: In the event of any discrepancy between the copies, the hard copy marked "Original" will control.

7.1.3.5. Front cover labeled with:

a. Name of company / organization;

b. RFP#; and
c. Technical Proposal.

7.1.4. Cost Proposal

7.1.4.1. Original in 3 ring binder marked as “Original.”

7.1.4.2. A copy of the Transmittal Letter marked as “Copy” as the first page of the Cost Proposal.

7.1.4.3. 2 copies in bound format marked as “Copy.”

7.1.4.4. 1 electronic copy (divided into folders that correspond to and are labeled the same as the hard copies). NOTE: In the event of any discrepancy between the copies, the hard copy marked “Original” will control.

7.1.4.5. Front cover labeled with:

a. Name of company / organization;
b. RFP#; and
c. Cost Proposal.

7.2. Outline and Detail

7.2.1. Proposal Contents – Outline

Each Proposal shall contain the following, in the order described in this section: (Each of these components must be separate from the others and uniquely identified with labeled tabs.)

7.2.2. Technical Proposal Contents – Detail

7.2.2.1. Transmittal Cover Letter

The Transmittal Cover Letter must be:

a. On the Bidding company’s letterhead;
b. Signed by an individual who is authorized to bind the Bidding Company to all statements, including services and prices contained in the Proposal; and
c. Contain the following:
    i. Identify the submitting organization;
    ii. Identify the name, title, mailing address, telephone number and email address of the person authorized by the organization to contractually obligate the organization;
    iii. Identify the name, title, mailing address, telephone number and email address of the fiscal agent of the organization;
    iv. Identify the name, title, telephone number, and e-mail address of the person who will serve as the Bidder’s representative for all matters relating to the RFP;
    v. Acknowledge that the Bidder has read this RFP, understands it, and agrees to be bound by its requirements;
    vi. Explicitly state acceptance of terms, conditions, and general instructions stated in Section 8 Mandatory Business Specifications, Contract Terms and Conditions;
    vii. Confirm that Appendix A Exceptions to Terms and Conditions is included in the proposal;

viii. Explicitly state that the Bidder's submitted Proposal is valid for a minimum of two hundred forty (240) days from the Technical and Cost Proposal Submission Deadline specified in Section 6.2;
ix. Date Proposal was submitted; and
x. Signature of authorized person.

7.2.2.2. Table of Contents

The required elements of the Proposal shall be numbered sequentially and represented in the Table of Contents.

7.2.2.3. Executive Summary

The Bidder shall submit an executive summary to:

a. Provide DHHS with an overview of the Bidder's organization and what is intended to be provided by the Bidder;
b. Demonstrate the Bidder's understanding of the services requested in this RFP and any problems anticipated in accomplishing the work;
c. Show the Bidder's overall design of the project in response to achieving the deliverables as defined in this RFP; and
d. Specifically demonstrate the Bidder's familiarity with the project elements, its solutions to the problems presented and knowledge of the requested services.

7.2.2.4. Proposal Narrative, Project Approach, and Technical Response

The Bidder must answer all questions and must include all items requested for the Proposal to be considered. The Bidder must address every section of Section 3 Statement of Work, even though certain sections may not be scored.

Responses must be in the same sequence and format as listed in Section 3 Statement of Work and must, at a minimum, cite the relevant section, subsection, and paragraph number, as appropriate.

7.2.2.5. Description of Organization

Bidders must include in their Proposal a summary of their company's organization, management and history and how the organization's experience demonstrates the ability to meet the needs of requirements in this RFP.

a. At a minimum respond to:
i. General company overview;
ii. Ownership and subsidiaries;
iii. Company background and primary lines of business;
iv. Number of employees;
v. Headquarters and Satellite Locations;
vi. Current project commitments;
vii. Major government and private sector clients; and
viii. Mission Statement.
b. This section must include information on:
i. The programs and activities of the organization;
ii. The number of people served; and
iii. Programmatic accomplishments.

c. And also include:
   i. Reasons why the organization is capable of effectively completing the services outlined in the RFP; and
   ii. All strengths that are considered an asset to the program.
d. The Bidder should demonstrate:
   i. The length, depth, and applicability of all prior experience in providing the requested services;
   ii. The skill and experience of staff and the length, depth and applicability of all prior experience in providing the requested services.

7.2.2.6. Bidder's References

The Proposal must include relevant information about at least three (3) similar or related contracts or subcontracts awarded to the Bidder and must also include client testimonials. Particular emphasis should be placed on previous contractual experience with government agencies. DHHS reserves the right to contact any reference so identified. The information must contain the following:

a. Name, address, telephone number, and website of the customer;
b. A description of the work performed under each contract;
c. A description of the nature of the relationship between the Bidder and the customer;
d. Name, telephone number, and e-mail address of the person whom DHHS can contact as a reference; and
e. Dates of performance.

7.2.2.7. Staffing and Resumes

Each Bidder shall submit an organizational chart and a staffing plan for the program. For persons currently on staff with the Bidder, the Bidder shall provide names, title, qualifications and resumes. For staff to be hired, the Bidder shall describe the hiring process and the qualifications for the position and the job description. The State reserves the right to accept or reject dedicated staff individuals.

7.2.2.8. Subcontractor Letters of Commitment (if applicable)

If subcontractors are part of this proposal, signed letters of commitment from the subcontractor are required as part of the RFP. The Bidder shall be solely responsible for meeting all requirements and terms and conditions specified in this RFP, its Proposal, and any resulting contract, regardless of whether it proposes to use any subcontractors. The Bidder and any subcontractors shall commit to the entire contract period stated within the RFP, unless a change of subcontractors is specifically agreed to by the State. The State reserves the right to approve or reject subcontractors for this project and to require the Bidder to replace subcontractors found to be unacceptable.

7.2.2.9. License, Certificates and Permits as Required

This includes: a Certificate of Good Standing, dated on or after April 1, 2016, or assurance of obtaining registration with the New Hampshire Office of the Secretary of State. Required licenses or permits to provide services as described in Section 3 of this RFP.

a. CAHPS credentials for all individuals the Bidder intends to assign to provide services, where appliacable, under the contract.

7.2.2.10. Affiliations – Conflict of Interest

The Bidder must include a statement regarding any and all affiliations that might result in a conflict of interest. Explain the relationship and how the affiliation would not represent a conflict of interest.

7.2.2.11. Required Attachments

The following are required statements that must be included with the Proposal. The Bidder must complete the correlating forms found in the RFP Appendices and submit them as the "Required Attachments" section of the Proposal.

a. Bidder Information and Declarations: Exceptions to Terms and Conditions, Appendix A

7.2.3. Cost Proposal Contents – Detail

7.2.3.1. Cost Bid Requirements

Cost proposals may be adjusted based on the final negotiations of the scope of work. See Section 4, Finance for specific requirements.

7.2.3.2. Statement of Bidder's Financial Condition

The organization's financial solvency will be evaluated. The Bidder's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered.

Each Bidder must submit audited financial statements for the four (4) most recently completed fiscal years that demonstrate the Bidder's organization is in sound financial condition. Statements must include a report by an independent auditor that expresses an unqualified or qualified opinion as to whether the accompanying financial statements are presented fairly in accordance with generally accepted accounting principles. A disclaimer of opinion, an adverse opinion, a special report, a review report, or a compilation report will be grounds for rejection of the proposal.

Complete financial statements must include the following:

a. Opinion of Certified Public Accountant
b. Balance Sheet
c. Income Statement
d. Statement of Cash Flow
e. Statement of Stockholder's Equity of Fund Balance
f. Complete Financial Notes
g. Consolidating and Supplemental Financial Schedules

A Bidder, which is part of a consolidated financial statement, may file the audited consolidated financial statements if it includes the consolidating schedules as supplemental information. A Bidder, which is part of a consolidated financial statement, but whose certified consolidated financial statements do not contain the consolidating schedules as supplemental information, shall, in addition to the audited consolidated financial statements, file unaudited financial statements for the Bidder alone accompanied by a certificate of authenticity signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification which attests that the financial statements are correct in all material respects.

If a bidder is not otherwise required by either state or federal statute to obtain a certification of audit of its financial statements, and thereby elects not to obtain such certification of audit, the bidder shall submit as part of its proposal:

a. Uncertified financial statements; and
b. A certificate of authenticity which attests that the financial statements are correct in all material respects and is signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification.

7.2.3.3. Required Attachments

The following are required statements that must be included with the Proposal. The Bidder must complete the correlating forms found in the RFP Appendices and submit them as the “Required Attachments” section of the Proposal.

a. Bidder Information and Declarations:
   i. Exceptions to Terms and Conditions, Appendix A
   ii. CLAS Requirements, Appendix D
   iii. Project Staff List, Appendix C

The rest of this page intentionally left blank.

8. MANDATORY BUSINESS SPECIFICATIONS

8.1. Contract Terms, Conditions and Penalties, Forms

8.1.1. Contract Terms and Conditions

The State of New Hampshire sample contract is attached; Bidder to agree to minimum requirement as set forth in the Appendix B.

8.1.2. Penalties

The State intends to negotiate with the awarded vendor to include liquidated damages in the Contract in the event any deliverables are not met.

The Department and the Contractor agree that the actual damages that the Department will sustain in the event the Vendor fails to maintain the required performance standards throughout the life of the contract will be uncertain in amount and difficult and impracticable to determine. The Contractor acknowledges and agrees that any failure to achieve required performance levels by the Contractor will more than likely substantially delay and disrupt the Department's operations. Therefore the parties agree that liquidated damages shall be determined as part of the contract specifications.

Assessment of liquidated damages shall be in addition to, and not in lieu of, such other remedies as may be available to the Department. Except and to the extent expressly provided herein, the Department shall be entitled to recover liquidated damages applicable to any given incident.

The Department will determine compliance and assessment of liquidated damages as often as it deems reasonable necessary to ensure required performance standards are met. Amounts due the State as liquidated damages may be deducted by the State from any fees payable to the Contractor and any amount outstanding over and above the amounts deducted from the invoice will be promptly tendered by check from the Contractor to the State.

9. ADDITIONAL INFORMATION

9.1. Appendix A – Exceptions to Terms and Conditions

9.2. Appendix B – Contract Minimum Requirements

9.3. Appendix C – Project Staff List

9.4. Appendix D – CLAS Requirements

9.5. Appendix E – Special Terms and Conditions

9.6. Appendix F – Premium Assistance Program Evaluation Plan

APPENDIX A

EXCEPTIONS TO TERMS AND CONDITIONS

A Responder shall be presumed to be in agreement with the terms and conditions of the RFP unless the Responder takes specific exception to one or more of the conditions on this form.

RESPONDERS ARE CAUTIONED THAT BY TAKING ANY EXCEPTION THEY MAY BE MATERIALLY DEVIATING FROM THE RFP SPECIFICATIONS. IF A RESPONDER MATERIALLY DEVIATES FROM A RFP SPECIFICATION, ITS PROPOSAL MAY BE REJECTED.

A material deviation is an exception to a specification which 1) affords the Responder taking the exception a competitive advantage over other Responders, or 2) gives the State something significantly different than the State requested.

INSTRUCTIONS: Responders must explicitly list all exceptions to State of NH minimum terms and conditions. Reference the actual number of the State's term and condition and Exhibit number for which an exception(s) is being taken. If no exceptions exist, state "NONE" specifically on the form below. Whether or not exceptions are taken, the Responder must sign and date this form and submit it as part of their Proposal. (*Add additional pages if necessary*.)

Responder Name:	
Term & Condition Number/Provision	**Explanation of Exception**

By signing this form, I acknowledge that the above named Responder accepts, without qualification, all terms and conditions stated in this RFP Section 8- Mandatory Business Specifications, Contract Terms and Conditions except those clearly outlined as exceptions above.

_____ _____ _____

Signature Title Date

FORM NUMBER P-37 (version 5/8/15)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name		1.2 State Agency Address	
1.3 Contractor Name		1.4 Contractor Address	
1.5 Contractor Phone Number	1.6 Account Number	1.7 Completion Date	1.8 Price Limitation
1.9 Contracting Officer for State Agency		1.10 State Agency Telephone Number	
1.11 Contractor Signature		1.12 Name and Title of Contractor Signatory	
1.13 Acknowledgement: State of , County of On , before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace [Seal]			
1.13.2 Name and Title of Notary or Justice of the Peace			
1.14 State Agency Signature Date:		1.15 Name and Title of State Agency Signatory	
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: On:			
1.18 Approval by the Governor and Executive Council *(if applicable)* By: On:			

2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials _____
Date_____

Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.
9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.
9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.
9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.
The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

Contractor Initials _____
Date_____

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.
15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.
15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. **WAIVER OF BREACH.** No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials _____
Date_____

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.
   Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name:

_____ _____

Date Name:
Title:

CERTIFICATION REGARDING LOBBYING

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor Name:

_____ _____

Date

Name:
Title:

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions,” without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

_____ Date

_____ Name:
Title:

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

_____ _____

Date

Name:
Title:

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

_____ _____

Date Name:
Title:

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) l, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

_____	_____
The State	Name of the Contractor
_____	_____
Signature of Authorized Representative	Signature of Authorized Representative
_____	_____
Name of Authorized Representative	Name of Authorized Representative
_____	_____
Title of Authorized Representative	Title of Authorized Representative
_____	_____
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

_____ _____

Date

Name:
Title:

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: _____

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   _____ NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

APPENDIX C

Project Staff List

New Hampshire Department of Health and Human Services

Bidder Name:

Services: Premium Assistance Program Evaluation Plan Implementation

A	B
Incumbent Name	**Position Title**

*Please list which site(s) each staff member works at if your organization has multiple sites.

APPENDIX D

Addendum to CLAS Section of RFP for Purpose of Documenting Title VI Compliance

All DHHS bidders are required to complete the following two (2) steps as part of their proposal:

(1) Perform an individualized organizational assessment, using the four-factor analysis, to determine the extent of language assistance to provide for programs, services and/or activities; and;
(2) Taking into account the outcome of the four-factor analysis, respond to the questions below.

Background:

Title VI of the Civil Rights Act of 1964 and its implementing regulations provide that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program that receives Federal financial assistance. The courts have held that national origin discrimination includes discrimination on the basis of limited English proficiency. Any organization or individual that receives Federal financial assistance, through either a grant, contract, or subcontract is a covered entity under Title VI. Examples of covered entities include the NH Department of Health and Human Services and its contractors.

Covered entities are required to take reasonable steps to ensure ***meaningful access*** by persons with limited English proficiency (LEP) to their programs and activities. LEP persons are those with a limited ability to speak, read, write or understand English.

The **key** to ensuring meaningful access by LEP persons is effective communication. An agency or provider can ensure effective communication by developing and implementing a language assistance program that includes policies and procedures for identifying and assessing the language needs of its LEP clients/applicants, and that provides for an array of language assistance options, notice to LEP persons of the right to receive language assistance free of charge, training of staff, periodic monitoring of the program, and translation of certain written materials.

The Office for Civil Rights (OCR) is the federal agency responsible for enforcing Title VI. OCR recognizes that covered entities vary in size, the number of LEP clients needing assistance, and the nature of the services provided. Accordingly, covered entities have some flexibility in how they address the needs of their LEP clients. (In other words, it is understood that one size language assistance program does not fit all covered entities.)

The **starting point** for covered entities to determine the extent of their obligation to provide LEP services is to apply a four-factor analysis to their organization. It is important to understand that the flexibility afforded in addressing the needs of LEP clients ***does not diminish*** the obligation covered entities have to address those needs.

APPENDIX D

Examples of practices that may violate Title VI include:

- Limiting participation in a program or activity due to a person's limited English proficiency;
- Providing services to LEP persons that are more limited in scope or are lower in quality than those provided to other persons (such as then there is no qualified interpretation provided);
- Failing to inform LEP persons of the right to receive free interpreter services and/or requiring LEP persons to provide their own interpreter;
- Subjecting LEP persons to unreasonable delays in the delivery of services.

BIDDER STEP #1 – Individualized Assessment Using Four-Factor Analysis

The four-factor analysis helps an organization determine the right mix of services to provide to their LEP clients. The right mix of services is based upon an individualized assessment, involving the balancing of the following four factors.

(1) The **number** or proportion of LEP persons served or likely to be encountered in the population that is eligible for the program;
(2) The **frequency** with which LEP individuals come in contact with the program, activity or service;
(3) The **importance** or impact of the contact upon the lives of the person(s) served by the program, activity or service;
(4) The **resources** available to the organization to provide effective language assistance.

This addendum was created to facilitate bidders' application of the four-factor analysis to the services they provide. At this stage, bidders are not required to submit their four-factor analysis as part of their proposal. **However, successful bidders will be required to submit a detailed description of the language assistance services they will provide to LEP persons to ensure meaningful access to their programs and/or services, within 10 days of the date the contract is approved by Governor and Council.** For further guidance, please see the Bidder's Reference for Completing the Culturally and Linguistically Appropriate Services (CLAS) Section of the RFP, which is available in the Vendor/RFP Section of the DHHS website:

http://www.dhhs.nh.gov/business/index.htm

APPENDIX D

Important Items to Consider When Evaluating the Four Factors.

Factor #1 The number or proportion of LEP persons served or encountered in the population that is eligible for the program.

Considerations:

- The eligible population is specific to the program, activity or service. It includes LEP persons serviced by the program, as well as those directly affected by the program, activity or service.
- Organizations are required not only to examine data on LEP persons served by their program, but also those in the community who are ***eligible*** for the program (but who are not currently served or participating in the program due to existing language barriers).
- Relevant data sources may include information collected by program staff, as well as external data, such as the latest Census Reports.
- Recipients are required to apply this analysis to each language in the service area. When considering the number or proportion of LEP individuals in a service area, recipients should consider whether the minor children their programs serve have LEP parent(s) or guardian(s) with whom the recipient may need to interact. It is also important to consider language minority populations that are eligible for the programs or services, but are not currently served or participating in the program, due to existing language barriers.
- An effective means of determining the number of LEP persons served is to record the preferred languages of people who have day-to-day contact with the program.
- It is important to remember that the ***focus*** of the analysis is on the lack of English proficiency, not the ability to speak more than one language.

Factor #2: The frequency with which LEP individuals come in contact with the program, activity or service.

- The more frequently a recipient entity has contact with individuals in a particular language group, the more likely that language assistance in that language is needed. For example, the steps that are reasonable for a recipient that serves an LEP person on a one-time basis will be very different from those that are expected from a recipient that serves LEP persons daily.
- Even recipients that serve people from a particular language group infrequently or on an unpredictable basis should use this four-factor analysis to determine what to do if an LEP person seeks services from their program.
- The resulting plan may be as simple as being prepared to use a telephone interpreter service.
- The key is to have a plan in place.

Factor #3 The importance or impact of the contact upon the lives of the person(s) served by the program, activity or service.
• The more important a recipient's activity, program or service, or the greater the possible consequence of the contact to the LEP persons, the more likely language services are needed. • When considering this factor, the recipient should determine both the importance, as well as the urgency of the service. For example, if the communication is both important and urgent (such as the need to communicate information about an emergency medical procedure), it is more likely that immediate language services are required. If the information to be communicated is important but not urgent (such as the need to communicate information about elective surgery, where delay will not have any adverse impact on the patient's health), it is likely that language services are required, but that such services can be delayed for a reasonable length of time.
Factor #4 The resources available to the organization to provide effective language assistance.
• A recipient's level of resources and the costs of providing language assistance services is another factor to consider in the analysis. • Remember, however, that cost is merely one factor in the analysis. Level of resources and costs do not diminish the requirement to address the need, however they may be considered in determining how the need is addressed; • Resources and cost issues can often be reduced, for example, by sharing language assistance materials and services among recipients. Therefore, recipients should carefully explore the most cost-effective means of delivering quality language services prior to limiting services due to resource limitations.

APPENDIX D

BIDDER STEP #2 - Required Questions Relating to Language Assistance Measures

Taking into account the four-factor analysis, please answer the following questions in the six areas of the table below. (**Do not** attempt to answer the questions until you have completed the four-factor analysis.) The Department understands that your responses will depend on the outcome of the four-factor analysis. The requirement to provide language assistance does not vary, but the measures taken to provide the assistance will necessarily differ from organization to organization.

1. IDENTIFICATION OF LEP PERSONS SERVED OR LIKELY TO BE ENCOUNTERED IN YOUR PROGRAM		
a. Do you make an effort to identify LEP persons served in your program? (One way to identify LEP persons served in your program is to collect data on ethnicity, race, and/or preferred language.)	Yes	No
b. Do you make an effort to identify LEP persons likely to be encountered in the population eligible for your program or service? (One way to identify LEP persons likely to be encountered is by examining external data sources, such as Census data)	Yes	No
c. Does you make an effort to use data to identify new and emerging population or community needs?	Yes	No
2. NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE		
Do you inform all applicants / clients of their right to receive language / communication assistance services at no cost? **(Or, do you have procedures in place to notify LEP applicants / clients of their right to receive assistance, if needed?)** Example: One way to notify clients about the availability of language assistance is through the use of an "I Speak" card.	Yes	No
3. STAFF TRAINING		
Do you provide training to personnel at all levels of your organization on federal civil rights laws compliance and the procedures for providing language assistance to LEP persons, if needed?	Yes	No

4. PROVISION OF LANGUAGE ASSISTANCE		
Do you provide language assistance to LEP persons, free of charge, in a timely manner? **(Or, do you have procedures in place to provide language assistance to LEP persons, if needed)**	Yes	No

APPENDIX D

In general, covered entities are required to provide two types of language assistance: (1) oral interpretation and (2) translation of written materials. Oral interpretation may be carried out by contracted in-person or remote interpreters, and/or bi-lingual staff. (Examples of written materials you may need to translate include vital documents such as consent forms and statements of rights.)			
5. ENSURING COMPETENCY OF INTERPRETERS USED IN PROGRAM AND THE ACCURACY OF TRANSLATED MATERIALS			
a. Do you make effort to assess the language fluency of all interpreters used in your program to determine their level of competence in their specific field of service? (Note: A way to fulfill this requirement is to use certified interpreters only.)	Yes	No	
b. As a general rule, does your organization avoid the use of family members, friends, and other untested individual to provide interpretation services?	Yes	No	
c. Does your organization have a policy and procedure in place to handle client requests to use a family member, friend, or other untested individual to provide interpretation services?	Yes	No	
d. Do you make an effort to verify the accuracy of any translated materials used in your program (or use only professionally certified translators)? (Note: Depending on the outcome of the four-factor analysis, N/A (Not applicable) may be an acceptable response to this question.	Yes	No	N/A
6. MONITORING OF SERVICES PROVIDED			
Does you make an effort to periodically evaluate the effectiveness of any language assistance services provided, and make modifications, as needed?	Yes		No
If there is a designated staff member who carries out the evaluation function? If so, please provide the person's title: _____	Yes		No

By signing and submitting this attachment to RFP#_____, the Contractor affirms that it:

1.) Has completed the four-factor analysis as part of the process for creating its proposal, in response to the above referenced RFP.
2.) Understands that Title VI of the Civil Rights Act of 1964 requires the Contractor to take reasonable steps to ensure meaningful access to ***all*** LEP persons to all programs, services, and/or activities offered by my organization.

3.) Understands that, if selected, the Contractor will be required to submit a detailed description of the language assistance services it will provide to LEP persons to ensure meaningful access to programs and/or services, within 10 days of the date the contract is approved by Governor and Council.

Contractor/Vendor Signature	Contractor's Representative Name/Title
Contractor Name	Date

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00298/1

TITLE: **New Hampshire Health Protection Program Premium Assistance**

AWARDEE: **New Hampshire Department of Health and Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Hampshire Health Protection Program Premium Assistance section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the State of New Hampshire (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs further set forth in detail the nature, character, and extent of Federal involvement in the demonstration, the state's implementation of the waivers and expenditure authorities, and the state's obligations to CMS during demonstration period. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population will begin on November 1, 2015 at which time Medicaid eligible adults can enroll into health coverage under qualified health plans (QHPs) and receive premium assistance with coverage effective January 1, 2016. This demonstration will sunset after December 31, 2016 consistent with the current legislative approval for the New Hampshire Health Protection Program pursuant to N.H. RSA 126-A:5,XXIII-XXV, but may continue for up to two additional years, through December 31, 2018, if the New Hampshire legislature authorizes the state to continue the demonstration and the state provides notice to CMS, as described in these STCs.

The STCs have been arranged into the following subject areas:

XV. Health Information Technology and Premium Assistance
XVI. T-MSIS

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the NHHPP Premium Assistance demonstration, the state will use premium assistance to support the purchase of coverage by beneficiaries eligible under the new adult group provided by certain qualified health plans (QHPs) doing business in the individual market through the Marketplace. The demonstration will affect individuals in the new adult group covered under Title XIX of the Social Security Act who are adults from age 19 up to and including 64 with incomes up to and including 133 percent of the federal poverty level (FPL) who are neither enrolled in (or eligible for) Medicare or employer-sponsored insurance.

New Hampshire expects approximately 50,000 beneficiaries to be enrolled into the Marketplace through this demonstration program. NHHPP Premium Assistance beneficiaries will receive the State plan Alternative Benefit Plan (ABP) and will have cost sharing obligations consistent with the state plan, as amended by the state. The ABP is the same benchmark plan chosen by the New Hampshire Marketplace to establish Essential Health Benefits. QHP will pay primary for covered services. QHP payment rates will be considered payment in full for covered services, and individuals affected by the demonstration will be limited to the QHP provider network, except in the case of family planning providers.

The demonstration will further the objectives of Title XIX by reducing coverage disruptions for individuals moving between Medicaid and the Marketplace due to changes in income. The demonstration will also test whether the premium assistance structure and resulting coverage affords beneficiaries access to wider provider networks, provides for higher provider payments for covered services, encourages more cross-participation by plans in Medicaid and the Exchange, and achieves cost reductions due to greater competition.

The state proposes to evaluate whether the demonstration will achieve the following goals-

- Continuity of coverage- For individuals whose incomes fluctuate, the demonstration will permit continuity of health plans and provider networks. Individuals and families may receive coverage through the same health plans and may seek treatment and services through the same providers regardless of whether their underlying coverage is financed by Medicaid or through the Marketplace. The state will evaluate whether individuals remain in the same QHP when Medicaid payment is terminated.
- Plan Variety - The demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace would afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and would increase the selection of plans for both Medicaid and Marketplace enrollees. The state will evaluate whether there is an increase in plan variety because of this cross-program participation.

- Cost Effective Coverage -- The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs. This, in turn, may result in coverage that achieves cost reductions in comparison to direct Medicaid coverage. The state will evaluate whether QHP coverage is cost effective, looking at the entire demonstration period and trends that emerge as the demonstration proceeds.
- Uniform provider access- The state will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** If the eligibility of a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

    a. Should the state amend the state plan to make any changes to eligibility for this population, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request a corresponding technical correction to the demonstration.

6. **Changes Subject to the Amendment Process.** Changes related to demonstration features including eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to the demonstration without prior approval by CMS through an amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC **7** below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An up-to-date CHIP allotment neutrality worksheet, if necessary; and

    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Option to Continue Demonstration Beyond DY 1. If the state intends to continue operating this demonstration beyond DY 1 and the legislature authorizes such continuation, the state must submit a letter of intent to CMS no later than 6 months prior to the end of each DY for which the state seeks continuation of the demonstration,. Otherwise, the state should submit a phase-out plan consistent with the requirements of STC 10.

9. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than six months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 10.

a. Compliance with Transparency Requirements at 42 CFR §431.412.

b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 16.

10. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised plan.

b. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.

c. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage

for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR Section 435.916.

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).

f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

11. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 46 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 48.

12. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.

13. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the

affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration enrollees as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration enrollee requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling enrollees.

14. **Withdrawal of Waiver Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.

15. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

16. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), to the extent applicable. The state must also comply, to the extent applicable, with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements

contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The state must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

17. Federal Financial Participation (FFP). No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. Eligibility

18. Populations Affected by the NHHPP Premium Assistance Demonstration. Except as described in STCs 19, 20, and 23, the NHHPP Premium Assistance Demonstration affects the coverage and delivery of benefits for adults aged 19 through 64 eligible under the state plan consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR Section 435.119 who are not medically frail or enrolled in employer sponsored insurance (ESI). Eligibility and coverage for these individuals are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except to the extent expressly waived. Implementation of such waiver authority must be consistent with these STCs. Any Medicaid state plan amendments to this eligibility group will apply to this demonstration.

Medicaid State Plan Mandatory Groups	Federal Poverty Level	Funding Stream	Expenditure and Eligibility Group Reporting
Adults in Section VIII Group	Adults at or below 133 percent FPL, who are not medically frail or enrolled in cost effective ESI coverage through the state HIPP program.	Title XIX	MEG – 1

19. **Medically Frail Individuals.** New Hampshire will institute a process to determine whether an individual is medically frail. The process will be described in the ABP state plan provisions. Individuals who are medically frail will be excluded from the demonstration.

20. **American Indian/Alaska Native Individuals.** Individuals identified as American Indian or Alaskan Native (AI/AN) have the ability to opt out of the demonstration and access the ABP offered under the Alternative Benefit State Plan. An AI/AN individual who does not opt out of enrolling in a QHP through the NHHPP Premium Assistance will be able to access covered benefits through I/T/U facilities. Under the Indian Health Care Improvement Act (IHCIA), AI/AN I/T/U facilities are entitled to payment notwithstanding network restrictions. As of the approval of this demonstration, there are no I/T/U facilities in the state of New Hampshire.

21. **Retroactive Coverage.** Prior to making any change in policies regarding retroactive coverage for the demonstration population, the state shall submit data to CMS to establish that there is seamless coverage that does not result in gaps in coverage prior to the time that a Medicaid application is filed, for individuals in the populations affected by the demonstration. The state will submit a description of its renewal process and data related to that process, as well as any relevant data related to coverage continuity to evaluate whether individuals are losing coverage upon renewal. Upon a CMS determination that sufficient data has been provided to establish that retroactive coverage prior to the date of application is not necessary to fill gaps in coverage, the state shall not have to provide retroactive coverage prior to the date of application under the demonstration; coverage for demonstration applicants will begin at the date of application.

V. NHHPP PREMIUM ASSISTANCE ENROLLMENT

22. **NHHPP Premium Assistance.** For individuals who are eligible for the NHHPP Premium Assistance, enrollment in a QHP will be mandatory unless the individual is determined to be exempt as described in STC 23.

23. Exclusions and Exemptions from Enrollment. The following individuals are either not permitted or not required to enroll in the NHHPP Premium Assistance.

a. Individuals who are eligible for the NH state plan Health Insurance Premium Payment (HIPP) Program for individuals with access to cost-effective ESI are ot permitted to enroll in NHHPP Premium Assistance.
b. Individuals who are determined to be medically frail are not permitted to enroll in NHHPP Premium Assistance.
c. Individuals who are AI/AN are not required to enroll in NHHPP Premium Assistance.

24. Notices. NHHPP Premium Assistance beneficiaries will receive a notice from New Hampshire Medicaid advising them of the following:

a. QHP Plan Selection. The notice will include information regarding how NHHPP Premium Assistance beneficiaries can select a QHP, including guidance on selecting the plan that will best address their needs and information on the state's auto-enrollment process in the event that the beneficiary does not select a plan.
b. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and Medicaid card. The notice will include information on how beneficiaries can use the CIN number or Medicaid card to access services until their QHP enrollment is effective.
c. Wrapped Benefits. The notice accompanying the Medicaid card will also include information on how enrollees can use the card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 37.
d. Appeals. The notice will also include information regarding the grievance and appeals process.
e. Exemption from the demonstration. The notice will include information describing how new adult enrollees who believe they may be exempt from the NHHPP Premium Assistance program can request an exemption determination. The notice will include information on the difference in benefits under the Premium Assistance ABP as compared to the other benefits available.
f. Additional Notices. The eligibility determination notice will advise that the NHHPP Premium Assistance program is subject to cancellation upon notice.

25. QHP Selection. The QHPs in which NHHPP Premium Assistance beneficiaries will enroll will be reviewed by the New Hampshire Insurance Department (NHID) and certified through the Federally Facilitated Marketplace's QHP certification process. The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.

26. Enrollment Process. The enrollment process will begin on November 1, 2015 through the following procedures for new applicants and transition population.

New Applicants:

a. Individuals will submit a joint application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions—electronically, via phone, by mail, or in-person.

b. An eligibility determination will be made through the New Hampshire Eligibility & Enrollment Framework (EEF).

c. Individuals determined to be Medicaid eligible will receive coverage through the State Plan until January 1, 2016, after which they will receive coverage through the demonstration except as specified in d.

d. Individuals who are determined to be medically frail based on the definition and process identified in the state's approved alternative benefit plan will be excluded from the demonstration and will receive direct coverage as described in the state plan Alternative Benefit Plan for the medically frail.

e. Individuals who are not identified as medically frail will receive a notice informing them that they may select a QHP and providing guidance on how to select a QHP. The notice will also include information on selecting a QHP and comparisons highlighting the differences between plans with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.

f. Individuals may select a QHP (1) through the state's online portal, NHEASY, (2) by phone, or (3) in person.

g. Individuals who fail to select a QHP within 30 days of an eligibility determination will be auto-assigned. New Hampshire will send individuals a notice informing them of the QHP to which they have been auto-assigned and that they have the right to select a different plan.

h. Once an individual has either selected a QHP or the time period to select a QHP has ended, New Hampshire will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.

i. Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.

j. On at least a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for New Hampshire's Department of Health and Human Services (NHHHS) to reconcile. Upon reconciliation NHHHS will send back an updated list for carriers.

k. The state's MMIS will generate an 820 transaction to pay premiums and cost sharing reductions on behalf of beneficiaries directly to the QHP issuer.

l. State MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail and excluded from the NHHPP Premium Assistance.

Transition Population:

a. Prior to and during the open enrollment period, New Hampshire Medicaid will send enrollees a notice informing them either: (1) that they have been auto-assigned to the QHP offered by their Medicaid managed care organization (MCO) in which they are currently enrolled (if the MCO elects to offer QHPs), but that they may select a different plan that is included in the NHHPP program or (2), if they have not been auto-assigned, that they may select a QHP that is included in the NHHPP Premium Assistance program. The notices will provide guidance on how to select a QHP. The notice will also include comparisons highlighting the differences between plans with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.

b. Individuals may select a QHP (1) through the state's online portal, NHEASY, (2) by phone, or (3) in person.

c. Individuals who were not auto-assigned to a QHP offered by their MCO and who fail to select a QHP within 30 days of receiving the notice informing them to select a QHP will be auto-assigned. New Hampshire Medicaid will send the individuals a notice informing them of the QHP to which they have been auto-assigned and that they have the right to select a different plan.

d. Once an individual has either selected a QHP or the time period to select a QHP has ended, New Hampshire will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.

e. Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.

f. On at least a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for New Hampshire's Department of Health and Human Services (NHHHS) to reconcile. Upon reconciliation NHHHS will send back an updated list for carriers.

g. The state's MMIS will generate an 820 transaction to pay premiums and cost sharing reductions on behalf of beneficiaries directly to the QHP issuer.

h. State MMIS premium and cost sharing reduction payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan

during the next open enrollment period; the individual is determined to be medically frail and excluded from the NHHPP Premium Assistance.

27. **Auto-assignment.** The following categories will be auto-assigned a QHP: (1) individuals who are enrolled in a Medicaid MCO that offers a QHP, and (2) individuals who are not enrolled in a Medicaid MCO or whose Medicaid MCO is not offering a QHP and who fail to select a QHP within 30 days of an eligibility determination or receipt of a notice to select a plan. New Hampshire Medicaid will send the individuals a notice informing them of the QHP to which they have been auto-assigned and their right to select a different plan. Individuals will be given a thirty-day period to request enrollment in another plan.

28. **Auto-assignment Methodology.** The auto-assignment methodology in DY 1 will take into account, among other factors, family affiliation, primary care provider affiliation, and premium costs.

29. **Changes to Auto-assignment Methodology.** The state will advise CMS 60 days prior to implementing a change to the auto-assignment methodology.

30. **Disenrollment.** Enrollees in the NHHPP Premium Assistance may be disenrolled if (i) they are determined to be medically frail after they were previously determined eligible or (ii) if they become enrolled in the mandatory HIPP program.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

31. **Memorandum of Understanding.** The New Hampshire Department of Health and Human Services shall enter into a memorandum of understanding (MOU) with each QHP issuer that will enroll individuals covered under the demonstration. Areas to be addressed in the MOU include, but are not limited to:

    a. Enrollment of individuals in populations affected by the demonstration;
    b. Payment of premiums and cost-sharing reductions;
    c. Reporting and data requirements necessary to monitor and evaluate the NHHPP Premium Assistance including those referenced in STC 71, ensuring coordination of benefits and enrollee access to EPSDT and other covered benefits through the QHP;
    d. Noticing requirements; and, audit rights.

32. **Qualified Health Plans.** The state will provide premium assistance to support the purchase of coverage for NHHPP Premium Assistance beneficiaries through Marketplace QHPs.

33. **Choice.** Each NHHPP Premium Assistance beneficiary will have the option to choose between at least two silver plans offered in the individual market through the Marketplace. The state will pay the full cost of QHP premiums and will provide cost sharing reductions.

    a. NHHPP Premium Assistance enrollees with incomes below 100 percent of the FPL will be enrolled in plans that effectively are 100 percent actuarial value (AV) high-value silver plans (after accounting for cost sharing reductions). Enrollees with incomes above 100 up

to 133 percent of the FPL will be enrolled in plans that effectively are 94 percent AV high-value silver plans (after accounting for cost sharing reductions).

b. NHHPP Premium Assistance beneficiaries will be able to choose from at least two silver plans in each rating area of the state.

c. The state will comply with Essential Community Provider network requirements, as part of the Qualified Health Plan certification process.

34. Coverage Prior to Enrollment in a QHP. The state will provide coverage through fee-for-service Medicaid from the date of application for coverage under the new adult group until the individual's enrollment in the QHP becomes effective.

a. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment).

b. For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).

VII. BENEFITS

35. Alternative Benefit Plan. Individuals affected by this demonstration will receive benefits described in an alternative benefit plan set forth in the approved state state plan. Individuals enrolled in QHPs will be restricted to the QHP provider network (except for family planning providers) to receive such benefits, and the QHP will pay primary to Medicaid for covered benefits. The QHP payment rate will be payment in full for such benefits.

36. Medicaid Wrap Benefits. The state will provide through its fee-for-service Medicaid program wrap-around benefits that are included in the ABP but not covered by qualified health plans. These benefits include non-emergency medical transportation (NEMT), early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21, family planning services and supplies, and certain limited adult dental and adult vision services.

37. Access to Wrap Around Benefits. In addition to receiving an insurance card from the applicable QHP issuer, NHHPP Premium Assistance beneficiaries will be sent a notice. The notice will contain information on how enrollees can use the card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 36.

38. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The state must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

39. Access to Federally Qualified Health Centers and Rural Health Centers. NHHPP Premium Assistance enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC.

VII. COST SHARING

40. Cost sharing. Cost sharing for NHHPP Premium Assistance enrollees must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR Section 447.56. All cost sharing on demonstration participants will be consistent with New Hampshire's approved state plan, as amended by the state.

41. Payment Process for Payment of Cost Sharing Reduction to QHPs. Agreements with QHP issuers may provide for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for NHHPP Premium Assistance beneficiaries. Such payments will be subject to reconciliation at the conclusion of the benefit year based on enrollee's actual usage of services. The state's reconciliation process will follow 45 CFR Section 156.430 to the extent possible.

IX. APPEALS

Beneficiary safeguards of appeal rights will be provided by the state, including fair hearing rights. No waiver will be granted related to appeals. The state must ensure compliance with all federal and state requirements related to beneficiary appeal rights.

X. GENERAL REPORTING REQUIREMENTS

42. General Financial Requirements. The state must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XII of these STCs.

43. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

44. Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the NHHPP Premium Assistance beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

Areas to be addressed include, but are not limited to:

1. Transition and implementation activities;
2. Stakeholder concerns;
3. QHP operations and performance;

4. Enrollment;
5. Cost sharing;
6. Quality of care;
7. Beneficiary access,
8. Benefit package and wrap around benefits;
9. Audits;
10. Lawsuits;
11. Financial reporting and budget neutrality issues;
12. Progress on evaluation activities and contracts;
13. Related legislative developments in the state; and
14. Any demonstration changes or amendments the state is considering.

45. Quarterly Progress Reports. The state will provide quarterly reports to CMS.

a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

46. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

47. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of DY 1 and after the end of each additional demonstration year, if applicable. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.

a. All items included in the quarterly report pursuant to STC 46 must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

48. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

49. Quarterly Expenditure Reports. The state must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XII of the STCs.

50. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, “expenditures subject to the budget neutrality limit,” is defined below in STC 62.

b. Cost Settlements. For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet sine 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.

c. Premium and Cost Sharing Contributions. To the extent New Hampshire collects premiums, Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to

demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.

e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The state must complete separate waiver forms for the following eligibility groups/waiver names:

i. MEG 1 – "New Adult Group"

f. The first Demonstration Year (DY1) will begin on January 1, 2016. In the event that the state requests an extension of the demonstration consistent with STC 8, subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	January 1, 2016	12 months
Demonstration Year 2 (DY2)	January 1, 2017	12 months
Demonstration Year 3 (DY3)	January 1, 2018	12 months

51. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs ("ADM").

52. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

53. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for the demonstration populations defined in STC 17. The state must submit a statement accompanying the quarterly report,

which certifies the accuracy of this information.

To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

54. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

55. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in STC 64:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

56. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

57. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments

that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

58. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 63, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

59. Risk. The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 63, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

60. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC63 below. In the event that there is more than one DY, the annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 63 below.

61. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 66. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

MEG	TREND	DY 1 - PMPM
New Adult Group	3.7%	$701.53

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

62. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

63. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

64. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, in the event that there is more than one Demonstration Year. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget	3%

	neutrality limit plus:	
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	0%

65. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

66. Submission of Evaluation Design. The state shall submit a draft evaluation design to CMS no later than 90 days after the award of the Demonstration. The evaluation design, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 3, is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the state. The state shall provide the Final Evaluation Design within 45 days of receipt of CMS comments. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment A.

67. Cost-effectiveness. While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the NHHPP Premium Assistance Demonstration using premium assistance when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

b. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the NHHPP Premium Assistance Demonstration compared to what would have happened for a comparable population in Medicaid Care Management.

c. The state will compare total costs under the NHHPP Premium Assistance Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

d. The state will compare changes in access and quality to associated changes in costs within the NHHPP Premium Assistance. To the extent possible, component contributions to changes in access and quality and their associated levels of

investment in New Hampshire will be determined and compared to improvement efforts undertaken in other delivery systems.

68. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall be a summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, data collection and analysis, interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

69. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

1. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

   The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

   i. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.

ii. Premium assistance beneficiaries will have equal or better access to preventive care services.
iii. Premium assistance beneficiaries will have lower non-emergent use of emergency room services.
iv. Premium assistance beneficiaries will have fewer gaps in insurance coverage.
v. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
vi. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.
vii. Premium assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
ix. Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
x. Premium assistance beneficiaries will have appropriate access to non-emergency transportation.
xi. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC 69 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
xii. The demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees.

a. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:

    1. Comparisons of provider networks;
    2. Consumer satisfaction and other indicators of consumer experience;
    3. Provider experience; and
    4. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

b. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in

comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered

c. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically valid sample size is available.

d. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the impact and/or effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the state may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Centers for Medicare and Medicaid Services Medicaid Adult Core measures, for meaningful use under HIT, or from the National Quality Forum. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.

e. Data Collection: This discussion shall include:
    1. A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:
        i. Medicaid encounter and claims data,
        ii. enrollment data, and
        iii. consumer and provider surveys

f. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.

g. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow to the greatest extent possible that the effects of the Demonstration are isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.

h. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

i. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the

selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

70. Interim Evaluation Report. If the state continues the demonstration beyond DY 1, then the state is required to submit a draft Interim Evaluation Report 90 days following completion of year two of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 72for the Final Summative Evaluation Report.

71. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from the Demonstration. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the expiration date of the Premium Assistance Demonstration, the State shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 30 days.

72. The Final Summative Evaluation Report. The Final Summative Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

73. State Presentations for CMS. The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 71. The State will present on its interim evaluation in conjunction with STC 72. The State will present on its summative evaluation in conjunction with STC 73.

74. Public Access. The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

a. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

75. Electronic Submission of Reports. The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.

76. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

77. Cooperation with Federal Learning Collaboration Efforts. The State will cooperate with improvement and learning collaboration efforts by CMS.

78. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

79. Deferral for Failure to Provide Summative Evaluation Reports on Time. The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue

deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIV. MONITORING

80. Quarterly Evaluation Operations Report. The State will provide quarterly reports to CMS. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration, including the reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

82. Annual Discussion with CMS. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

83. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

84. Health Information Technology (Health IT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

a. Health IT: New Hampshire must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange, to the greatest extent possible. Federal funding for developing HIE infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.

c. All requirements must also align with New Hampshire's State Medicaid HIT Plan, as applicable, and other planning efforts such as the ONC HIE Operational Plan.

XVI. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in New Hampshire against which the premium assistance demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

APPENDIX F

2016 NEW HAMPSHIRE HEALTH PROTECTION PROGRAM - *PREMIUM ASSISTANCE PROGRAM* WAIVER (NHHPP PAP)

WAIVER EVALUATION DESIGN PLAN

This program is operated under an 1115 Research and Demonstration Waiver initially approved by the Centers for Medicare & Medicaid Services (CMS) on March 4, 2015.

Table of Contents

1. BACKGROUND

Synopsis of New Hampshire Health Protection Program – Premium Assistance Waiver

On March 4, 2015, the New Hampshire Department of Health and Human Services (DHHS) received approval from the Center for Medicare & Medicaid Services (CMS) to develop the New Hampshire Health Protection Program's Premium Assistance Program component as an 1115 Medicaid Demonstration Waiver program. The New Hampshire Health Protection Program (NHHPP) Act includes three components: (1) a mandatory Health Insurance Premium Payment Program (HIPP) for individuals with access to cost-effective employer-sponsored insurance; (2) a bridge program to cover the new adult group in Medicaid managed care plans from August 15, 2014 through December 31, 2015; and (3) a mandatory individual qualified health plan (QHP) premium assistance program (PAP) beginning on January 1, 2016.

In accordance with CMS' waiver requirement, DHHS must develop an evaluation plan for the NHHPP PAP Demonstration waiver no later than 90 days following waiver approval from CMS. The proposed PAP evaluation plan is built on monitoring both process and outcome performance measures that increase in number over the three years potentially available for the waiver due to data varying in collection, processing, and finalization cycles. This increase in available evaluation data over time means that the data available towards the end of 2016 (i.e., first year of the NHHPP PAP) will not be complete and should be considered a first approximation for the first set of monitoring measures, rather than definitive results.

Enrollment activities for the PAP adult population will begin on or before November 1, 2015, depending on whether beneficiaries are enrolled in the Bridge Program. However, regardless of prior enrollment status, Medicaid eligible adults can enroll into health coverage under QHPs and receive premium assistance beginning November 1, 2015, for coverage effective January 1, 2016. This Demonstration will sunset after December 31, 2016 consistent with the current legislative approval for the New Hampshire Health Protection Program pursuant to N.H. RSA 126-A:5, XXIII-XXV, but may continue for up to two additional years, through December 31, 2018, if the New Hampshire legislature authorizes the State to continue the Demonstration and the State provides notice to CMS, as described in the Special Terms and Conditions.[1]

Key Components and Objectives of the QHP PAP

The NHHPP PAP Demonstration will assist the State in its goals to ensure:

[1] Special Terms and Conditions (STC) Document #11-W-00298/1.

1. **Continuity of coverage—*For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks;***[2]
2. **Plan variety—*The Demonstration will encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and will encourage QHP carriers to seek Medicaid managed care contracts;***
3. **Cost-effective coverage—*The premium assistance approach will increase QHP enrollment and result in greater economies of scale and competition among QHPs; and***
4. **Uniform provider access—*The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.***

New Hampshire's Demonstration evaluation will include an assessment of the following research hypotheses that address the four goals just described:[3]

1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
4. The Demonstration could lead to an increase in plan variety by encouraging health plans in the Medicaid Care Management Program to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management Program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees.

[2] The NHHPP PAP Demonstration does not include the medically frail population. Members who self-identify as medically frail will be dropped from the program and enrolled in traditional Medicaid. As such, they will be excluded from the evaluation using appropriate methods but will be counted to report on the frequency of self-declaration.

[3] Reordered from STC #69.1 i-xii to correspond with the content and ordering of four goals of the waiver, delineated on pages 2-3 of the Special Terms and Conditions document (pa_termsandconditions.pdf), and consistent with Appendices A, B, and D.

5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.
6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions.
7. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
9. Premium assistance beneficiaries will have equal or better access to preventive care services.
10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
11. Premium assistance beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.
12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation.

The evaluation design, taking into account the four goals and 12 hypotheses outlined above, considers through its performance measures and analysis plan the coverage for the following dimensions of access and quality, as shown in Appendix A:

- Comparisons of provider networks;
- Consumer satisfaction and other indicators of consumer experience;
- Provider experience; and
- Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes.

Each of these four aspects of access and quality is associated with specific measures tied to the 12 research hypotheses and are listed in Appendix A. Appendix A illustrates the relationship between the research hypotheses and Demonstration goals, while Appendix B addresses the specific measures used to evaluate each of the 12 research hypotheses.

2. EVALUATION DESIGN

The core purpose of the evaluation is to determine the costs and effectiveness of the NHHPP PAP, when considered in its totality, and taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes. The evaluation will explore and explain the effectiveness of the Demonstration for each research hypothesis, including total costs in accordance with the evaluation design as approved by CMS. As shown in Appendix B, each research hypothesis includes one or more evaluation measures. Wherever feasible, each measure will be in a standardized form comparable to and compared against national values.

Included in the evaluation will be examinations of NHHPP PAP performance on a set of access and clinical quality measures against a comparable population in the New Hampshire Medicaid Care Management Program. These measures will be taken from the list of required data fields for the claims submitted by each QHP for each PAP recipient. The State will compare costs (i.e., total, administrative, and medical) under the NHHPP Premium Assistance Demonstration to costs of what would have happened under a traditional Medicaid expansion. In this case, the evaluation will compare the costs of the PAP program to the estimated costs if that population would have remained in the Bridge program, which was created for Medicaid expansion.

The cost comparison will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses. The State will assess access and quality for the NHHPP PAP beneficiaries and Medicaid beneficiaries in managed care to ensure appropriate services are provided to the PAP beneficiaries. Moreover, to the extent possible, component contributions to changes in access and quality and their associated levels of investment in New Hampshire will be determined and compared to improvement efforts undertaken in other delivery systems.[4] Both cross-sectional and sequential cross-sectional analyses will be used, depending on the whether the measure is across one point in time or multiple points in time, along with the specific research hypothesis being addressed.

The operational details for the PAP evaluation are contained in the following four appendices:

- Appendix A – Evaluation Components
- Appendix B – Research Hypotheses, Groups, and Associated Methodologies
- Appendix C – Milestones and Timeline
- Appendix D – Rapid Cycle Assessment Measures

[4] To access and utilize administrative cost information, the non-encounter cost information will be generated by the State and provided to the evaluation contractor, as needed.

Before addressing the 12 research hypotheses and associated measures, the next section of the PAP evaluation plan defines the study and comparison groups, data sources, analytic methods, and limitations to the evaluation of the PAP Demonstration.

Study Population

The study population consists of all beneficiaries covered under Title XIX of the Social Security Act in the State of New Hampshire from 19 years through 64 years of age who are not medically frail, incarcerated, or enrolled in cost-effective employer sponsored insurance and who are enrolled in Medicaid managed care.[5] This study population will be divided into two groups to operationalize the evaluation—i.e., the study group and the comparison group.

Study Group

The study group is the NHHPP PAP group and consists of beneficiaries covered under Title XIX of the Social Security Act who are either:

1) Childless adults between the ages from 19 through 64 with incomes at or below 133 percent of the federal poverty level who are neither enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance or
2) Parents between the ages of 19 through 64 with incomes between 38 percent (for non-working parents) or 47 percent (for working parents) and 133 percent of the Federal Poverty Level and who are not enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance

The NHHPP PAP membership is estimated to contain approximately 45,000 beneficiaries.[6]

Comparison Groups

Two comparison groups are needed for this evaluation. The sequential cross-sectional comparison group (used in longitudinal analyses) consists of newly eligible members of the Bridge Program, most of whom will be eligible for the PAP program the following year. The Bridge Program is a transition program that enrolled Medicaid expansion beneficiaries into New Hampshire's Medicaid managed care program beginning in August 2014. Assuming these beneficiaries remain eligible, Bridge Program members

[5] Coverage and delivery of benefits to eligible members are consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR Section 435.119.

[6] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf , Page 9 of 146. Last accessed on May 28, 2015.

will be automatically enrolled in the PAP program in January 2016 leading to substantial overlap between the two populations. As such, the Bridge Program comparison group includes members enrolled in the Bridge Program beginning in August 2014 through December 31, 2015.

The non-PAP comparison group for all measures, except those derived through survey instruments,[7] consists of a statistically matched group of Title XIX beneficiaries in the State in parent/caretaker eligibility groups from 19 through 64 years of age who are not in the study group, not disabled, or incarcerated, and who are enrolled in a Managed Care Organization (MCO), updated at each measurement time.[8] The comparison group is estimated to contain between 12,000 and 15,000 beneficiaries, depending upon the number lost through the statistical matching process.[9] This group provides a baseline frame of reference for expected changes over time to assess the PAP program and its changes over time in subsequent years, if the PAP is continued. The start for this group's data should coincide with the start of the Bridge Program and its data.

Specifically for the cost-effectiveness analyses, the comparison group will consist of a statistically derived cohort of beneficiaries and their estimated costs if the Bridge Program were continued. The analysis will estimate what this population would have cost if the Bridge program continued past December 31, 2015, adjusting for items such as medical cost trend, demographic differences, acuity differences, and changes to targeted Bridge program provider reimbursement levels.

The evaluation of the Demonstration will be performed using rigorous actuarial and statistical methods to assess whether the beneficiaries in the NHHPP PAP are doing as well or better than in the Bridge program on the various measures in the evaluation. The population enrolled in the Bridge program will have very similar characteristics to the population enrolled in the PAP program, but the methodology will also use statistical matching techniques to ensure the populations used for comparison are as similar as possible. The analysis will compared the actual experience of the Bridge program population (trended and adjusted to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program. The methodology will be designed to determine the extent to which observed differences are statistically significant and meaningful to assess the research goals of the Demonstration.

[7] The evaluation contractor may use the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey or CAHPS-like survey for the intended data source. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[8] Statistical matching will be validated through a discriminant analysis with power set at approximately .8 for the comparison between groups on a set of criteria determined in coordination with subject matter experts.

[9] Email from Andrew Chalsma, Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services to Debra L. Chotkevys, Director, Professional Services, Health Services Advisory Group, Inc., on May 27, 2015.

Data Sources

New Hampshire is in the process of finalizing Memorandums of Understanding (MOU) with the QHPs for their participation in the PAP. While the MOUs are not yet signed, the Department and the QHPs have agreed on the terms that require the QHPs to provide encounter data to the state. The QHPs will submit data to the Department using the format and quality requirements of the State's Comprehensive Health Care Information System (CHIS), New Hampshire's All Payer Claims Database. Because the submission of data to the CHIS is a legal requirement to be a carrier in New Hampshire, the QHPs are already obligated to process and format the data according to the CHIS requirements. Existing CHIS data quality assurance processes will be employed to ensure the data are complete and of high quality. The QHPs will need to submit a separate duplicate feed for PAP members, because the CHIS data normally contain encrypted identifiers. The separate CHIS-like file the QHPs will provide to the Department will contain identifiers including member Medicaid ID which will allow linking the data to Medicaid membership and claims.

DHHS and its evaluation contractor will use multiple sources of data to assess the 12 research hypotheses. The data collected will include both administrative and survey-based data (e.g., CAHPS, CAHPS-like, telephonic information gathering). Administrative data sources include information extracted from DHHS's Medicaid Management Information System (MMIS), the State's Comprehensive Health Care Information System (CHIS), and the State's All-payer Hospital database. The three data sources are used to collect, manage, and maintain Medicaid recipient files (i.e., eligibility, enrollment, and demographics), fee-for-service (FFS) claims, and managed care encounter data. These data bases serve as central repositories for significant portions of the data DHHS will use to mine, collect, and query while addressing the 12 research hypotheses. DHHS and its evaluation vendor will work together with key data owners to ensure the appropriate data use agreements are in place to obtain the data. Data sharing Memorandums of Understandings (MOU) will be initiated with entities to allow access to and use of Medicaid claims and encounters, member demographics and eligibility/enrollment, and provider data.

Administrative Data

New Hampshire's Demonstration evaluation offers an opportunity to synthesize information from several data sources to determine the impact of the NHHPP PAP. The administrative data sources—i.e., CHIS, MMIS (including member, provider, and enrollment data), the All-payer Hospital databases—are necessary to address the 12 research hypothesis outlined in the evaluation design. Each measure (see Appendix B) associated with each research hypothesis lists the data source(s) used in addressing it. Three key fields that must be present to conduct the evaluation include the date of birth (for defining the study populations and some individual measures), a flag to identify whether a Medicaid recipient is enrolled in the PAP, and a flag to identify if the recipient is in a traditional Medicaid managed care.

Use of FFS claims and managed care encounters will be limited to final, paid status claims/ encounters. Interim transaction and voided records will be excluded from all evaluations, because these types of records introduce a level of uncertainty (from matching adjustments and third party liabilities to the index claims) that can impact reported rates.

CHIS

"The New Hampshire Comprehensive Health Care Information System (CHIS) was created by NH statute to make health care data 'available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.'"[10] The same legislation that created the CHIS also enacted statutes that mandated health insurance carriers to submit encrypted health care claims data and Health Employer Data and Information Set (HEDIS®[11]) data to the State. As a result, CHIS data will be useful in calculating several of the measures used in the Demonstration evaluation.

MMIS

Not all data required for the evaluation will be in the CHIS database. As such, access to Medicaid claims and encounters will be required to optimize the information available to calculate the various measures. In general, Medicaid encounters are received and processed by the State's fiscal agent on a weekly basis with a historical 'run-out' of three months. In addition to service utilization data, the NHHPP PAP evaluation will require access to supplemental Medicaid data contained in the State's MMIS—e.g., member demographics, eligibility/enrollment, and provider information.

New Hampshire Medicaid began processing managed care encounter data in July of 2015. New Hampshire is employing a three-fold strategy to ensure completeness and accuracy of the encounter data: 1) New Hampshire's Medicaid managed care contracts contain robust requirements for timeliness, completeness and accuracy with the possibility of liquidated damages if the standards are not met; 2) New Hampshire's encounter data processing solution pseudo adjudicates encounters through the State's MMIS applying many of the same quality edits employed for FFS claims; and 3) New Hampshire has availed itself of the optional EQRO activity of Encounter Data Validation (current EQRO contract includes activity and EQRO is currently implementing a EDI based solution for loading the data as part of validation). Because the processing of the data only began recently, NH does not yet have summary analysis on data quality. However, NH is confident that their strategies will produce valid and reliable data and is committed to that outcome.

[10] New Hampshire Comprehensive Health Care Information System. https://nhchis.com, Last accessed on May 26, 2015.
[11] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Member Demographics—Member data are used to assess member age, gender, and other demographic and economic information required for the calculation of specific measures. For example, member demographics are used to determine member's age in order to define the comparison group relative to the distribution of the population in the study group. Additionally, fields such as gender will be used for the prenatal and postpartum measures. Finally, key financial data will be used when assessing gaps in coverage.

Eligibility/Enrollment—The eligibility/enrollment file will also be used create the study and comparison groups, as well as the assessment of health insurance and enrollment gaps.

Provider—Provider data, such as office location and specialty, will be used to assess the availability of services for both study and comparison groups.

All-payer Hospital Data

All-payer Hospital Data will be used to generate baseline data on new enrollees to the NHHPP PAP. As newly enrolled members, data for this population will not be available in other State data sources since many of the NHHPP PAP beneficiaries will be new to Medicaid.

Consumer Surveys

CAHPS and/or CAHPS-like surveys will be used to assess satisfaction with provided health care services.[12] These instruments will include specific survey items designed to elicit information that address research hypotheses regarding members' continuity of health care coverage and health plan market diversity.

One option is for the State to work with New Hampshire's CAHPS vendor to seek approval from NCQA to supplement its annual CAHPS administration to include three evaluation-specific questions. These questions will be designed to capture elements of the waiver STCs that cannot be addressed through administrative data or currently collected survey items. These three items will address the following concepts:

1) Continuity in member health insurance coverage—research hypothesis 1 states that premium assistance beneficiaries will have equal or fewer gaps in health insurance coverage.
2) Continuous access to the same health plan—research hypothesis 2 states that premium assistance beneficiaries will have access to the same health plans and maintain continuous access to the same providers.

[12] Depending on the State's CAHPs vendor and survey logistics related to adding items to the annual CAHPS survey, DHHS may decide to administer a CAHP-like custom survey to maximize applicability to the study population and increase the likelihood of return.

3) Continuity in plan enrollment—research hypothesis 3 states that premium assistance beneficiaries will have equal or fewer gaps in plan enrollment leading to equal or greater continuity of care.

In choosing the potential responses for each of the three questions being proposed, the response categories will mimic other response categories used on the CAHPS form, such as the degree of respondent agreement with a statement or a Yes/No response. The final wording for each of the proposed items will be submitted to NCQA for review after collaboration with the State and its CAHPS vendor.

The CAHPS vendor is aware that the State is interested in comparing its Medicaid populations. For 2015, the CAHPS vendor has already prepared separate surveys for the NHHPP population and for the traditional Medicaid population. If the evaluation continues in successive years, the vendor will also separate the Medicaid population into three groups making the comparisons in this evaluation possible--i.e., the traditional managed care group, the NHHPP group, and the NHHPP PAP group.

An alternative option would be for the evaluation contractor to deploy an independent survey that is structured in a similar manner to CAHPS but could be administered in a more strategic and targeted manner than would normally be possible for CAHPS. This type of survey would capture the information required by each of the eight evaluation measures currently citing CAHPS as a potential data source.

Analytic Methods

The evaluation reporting will meet traditional standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation (e.g., for the evaluation design, data collection and analysis, and the interpretation and reporting of findings). The Demonstration evaluation will use the best available data, will use controls and adjustments where appropriate and available, and will report the limitations of data and the limitations' effects on interpreting the results. All research hypotheses and methods will incorporate results from sensitivity, specificity, and power analyses to ensure the validity of the evaluation findings. Lastly, the evaluation will discuss the generalizability of results in the context of the limitations.

As outlined earlier, the existence of the Bridge Program creates a unique comparison group for understanding various aspects of the Demonstration's research hypotheses. In order to ensure the appropriateness of comparisons, preliminary population profile reviews will be conducted on the Bridge and NHHPP PAP populations. These analyses will confirm key assumptions regarding the similarities and overlap in these populations on key demographic characteristics and serve as a foundation for future discriminant analyses and statistical matching. Furthermore, rates of enrollment (i.e., speed in reaching the eligible populations) will be assessed and compared for the Bridge Program and NHHPP PAP populations. As a result of the unique transition from Bridge Program to NHHPP PAP program, two distinct approaches to the analyses will be used in order to maximize the retention of beneficiaries in each group over time. Specifically, the evaluation analyses will include the following methods.

1. **Cross-sectional Analysis:** These analyses examine results for selected measures for two different groups at the same point in time. For example, cross-sectional analyses will be used to evaluate NHHPP PAP members' access to certain services versus non-NHHPP PAP MCO members' access.
2. **Sequential, Cross-sectional Analysis:** These analyses will include both *single group* and *multiple group* evaluations of multiple measures over time. Single group evaluations involve pre- and post-testing of a population that is conceptually longitudinal but changes some percentage of its membership each year, such as the Medicaid population. Multiple group evaluations involve pre- and post-testing for all evaluation groups to create difference scores that are then compared across groups.

Both comparative methods will be used in the following NHHPP PAP evaluation. The specific choice of methods depends on the measure under discussion and the theoretical and empirical implications for policy-relevant and defensible results. For this reason, the specific comparative method is detailed within each of the measures used in the evaluation (See Appendix B and Appendix D). If the Demonstration is continued for an additional one or two years, the measures are also continued using the analogously extended groups (i.e., Bridge becomes NHHPP PAP and 'becomes' NHHPP PAP for three cycles of measurement).

The three main analytic methods used to determine whether the beneficiaries in the NHHPP PAP are doing as well or better than Medicaid beneficiaries in the traditional Medicaid managed care program on the various measures in the evaluation are the t-test, the z-test, and discriminant analysis. The t-test will be used for pre-post single group methods of assessment (e.g., sequential cross-sectional) as well as for cross-sectional comparisons of two groups at one point in time. A z-test will be used for comparative sequential cross-sectional designs where a difference-in-differences approach (i.e., absolute or relative) is applied, depending on the measures and scales used for their assessment. A discriminant analysis will also be used to ensure that Non-PAP comparison group is appropriately and statistically matched to the study population.

In situations where neither the t-test nor z-test is appropriate (e.g., a need to risk-adjust), a fourth method, multiple regression analysis, will be used to determine the size of group differences through the grouping variable in the model. This method has a long history of generating empirically robust results when the evaluation model is correctly specified. The evaluation contractor will utilize clinical subject matter experts (SMEs) when building multivariate models and identifying relevant control variables.

The cost-effectiveness portion of the evaluation examines costs in three ways: total and the medical and administrative components that, when summed, represent total healthcare costs. As a result, all costs (and credits) are required to fit into either the medical or the administrative category. Both of the cost-effectiveness measures are reported in these three ways. There are three annual measures (i.e., 3-3, 7-1, and 7-2) and three rapid-cycle quarterly measures (i.e., CEC-1, CEC-2, and CEC-3) used assess the cost-effectiveness of the Demonstration. To do so, the costs (i.e., total and

breakdown for medical and administrative) will be tracked for comparing actual NHHPP PAP costs to the estimated costs if the Bridge program were continued. After evaluating the available data, these comparisons may be modified or additional cost effectiveness comparisons may be developed if they are deemed to further the research goals of the Demonstration.

Finally, where appropriate, supplemental analyses will be conducted to further investigate and understand the impact of the NHHPP PAP program. These analyses may include plan-based comparative findings as well as the stratification of results by key demographic and/or programmatic characteristics. When possible, evaluation results will incorporate national or state-defined standards and/or benchmarks for comparison purposes. Together, the findings from these sub-group analyses will further inform the State regarding the impact of the NHHPP PAP program.

Process/Outcome Measures

When possible, process measures will be used since they do not require any form of risk adjustment beyond eligibility. The reason is related to the nature of process measures in that the 'processes' are required for anyone who meets the inclusion and exclusion criteria for the measure. Theoretically, a process measure should be able to reach 100 percent among the eligible populations.

Outcome measures often require some form of risk adjustment or stratification. Certain demographic characteristics must be stratified for CMS reporting, such as race, rather than used as a risk-adjustment variable in a multivariate model. For comparison purposes, a comparison group is formed from the non-PAP MCO Medicaid beneficiaries such that a discriminant analysis with policy-relevant predictor variables cannot distinguish group membership beyond randomness, with statistical power set to approximately .8 for the comparison.

Comparative Statistics

The t-tests (and z-tests where appropriate) will be used to assess whether any differences found between the study and comparison groups are statistically significant (i.e., unlikely to have occurred in the data through random chance alone). The traditionally accepted risk of error ($p \leq .05$) will be used for all comparisons. If risk adjustment is used, p-values will be generated through multiple regression analysis and assessed against the same critical p-value.

Limitations

The limitations surrounding this evaluation center on the lack of truly comparative data for the NHHPP PAP members for outcome variables in the first year of the Demonstration beyond the All-payer Hospital data. When a new and empirically different group is added to Medicaid, there is often no comparison group with data to assess potential programmatic differences between the new group and the effects of

joining the ongoing Medicaid program, instead. As a result, assumptions on comparability are sometimes made that lack empirical evidence for support or that have somewhat inconsistent evidence of comparability.

Additionally, little or no data will exist in sufficient time for the New Hampshire legislature to decide whether it will continue the NHHPP PAP past its first year of operation. This situation will require the State legislature to make program decisions without the knowledge and support of the first annual evaluation of the program, or from the interim evaluation conducted after full implementation of the Demonstration.

3. REPORTING

Following its annual evaluation of the NHHPP PAP and subsequent synthesis of the results, DHHS and its evaluation vendor will prepare a report of the findings and how the results compare to the research hypotheses. Both the interim annual reports and the final summative evaluation report will be produced in alignment with STCs and the schedule of deliverables listed in Table 1 below. (See Appendix C for a detailed timeline.) Following approval to continue the NHHPP PAP in Year 2 and Year3 by the New Hampshire State Legislature, the schedule of deliverables will be updated to reflect additional reporting requirements.

Table 1—Schedule of Deliverables for the NHHPP PAP Waiver Evaluation

Deliverable	Date
NHHPP PAP Evaluation Design (STC #66)	
DHHS submits PAP Waiver Evaluation Methodology to CMS	6/4/2015
DHHS to post PAP Waiver Evaluation Methodology on the State's website for public comment	6/4/2015
DHHS to post final approved Evaluation Design on the State's website within 30 days of approval by CMS	On or before 10/15/2015
DHHS presentation to CMS on approved Evaluation Design (STC #73)	As Requested
Demonstration Year 1	
Quarterly: DHHS to report progress of Demonstration to CMS (STC #82)	30 days after the quarter
If Demonstration Continued, Interim Annual Evaluation Report (STC #70)	3/31/2017
If Demonstration Ended, Preliminary Summative Evaluation Report (STC #71)	6/29/2017
If Demonstration Ended, Final Summative Evaluation Report (STC #71)	12/31/17
DHHS presentation to CMS on Final Summative Evaluation Report (STC #73)	As Requested

Each evaluation report will present findings in a clear, accurate, concise, and timely manner. At minimum, all written reports will include the following six sections: Executive Summary, Demonstration Description, Study Design, Findings and Conclusions, Policy Implications, and Interactions with Other State Initiatives. Specifically, the reports will address the following:

1) The **Executive Summary** concisely states the goals for the Demonstration, the evaluation questions and hypotheses tested in the report, and updates on questions and hypotheses scheduled for future reports. In presenting the key findings, budget neutrality and cost-effectiveness will be placed in the context of policy-relevant implications and recommendations.

2) The **Demonstration Description** section focuses on programmatic goals and strategies, particularly related to budget neutrality and cost-effectiveness. The section succinctly traces the development of the program from the recognition of need to the present degree of implementation. This section will also include a discussion of the State's roll-out of the NHHPP PAP program along with its successes and challenges.

3) The **Study Design** section contains much of new information in the report. Its five sections include: evaluation design with the 12 research hypotheses and associated measures, along with the type of study design; impacted populations and stakeholders; data sources that include data collection field, documents, and collection agreements; analysis techniques with controls for differences in groups or with other State interventions, including sensitivity analyses when conducted; and limitations for the study.

4) The **Findings and Conclusions** section is a summary of the key findings and outcomes. The section focuses on cost-effectiveness, along with the successes, challenges, and lessons learned from the implementation of the Demonstration.

5) The **Policy Implications** section contains the policy-relevant and contextually appropriate interpretations of the conclusions. This section includes the existing and expected impact of the Demonstration within the health delivery system in the State in the context of the implications for State and federal health policy, including the potential for successful strategies to be replicated in other State Medicaid programs.

6) The **Interactions with Other State Initiatives** section contains a discussion of this Demonstration within an overall Medicaid context and consideration for the long-range planning efforts by the State. This discussion includes the interrelations between the Demonstration and other aspects of the State's Medicaid program, including interactions with other Medicaid waivers, the State Innovation Models (SIM) award, and other federal awards affecting service delivery, health outcomes, and the cost of care under Medicaid.

All reports, including the Evaluation Design, will be posted on the State Medicaid Website within 30 days of the approval of each document to ensure public access to evaluation documentation and to foster transparency. DHHS will notify CMS prior to publishing any results based on Demonstration evaluation for CMS' review and approval. The reports' appendices present more granular results and supplemental findings. The State will work with CMS to ensure the transmission of all required reports and documentation occurs within approved communication protocols.

4. EVALUATOR

Independent Entity

Based on State protocols, DHHS will follow established policies and procedures to acquire an independent entity or entities to conduct the NHHPP PAP Demonstration evaluation. The State will either undertake a competitive procurement for the evaluator or will contract with entities that have an existing contract relationship with the State. An assessment of potential vendors' experience, knowledge of State programs and populations, and resource requirements will determine selection of the final candidate, including steps to identify and/or mitigate any conflicts of interest.

Budget

Due to the complexity and resource requirements of the NHHPP PAP Demonstration, DHHS will need to conduct a competitive procurement to obtain the services of an independent entity to perform the services outlined in this evaluation design. As such, an estimated budget is currently unavailable and will be determined through the competitive bid process. Upon selection of an evaluation vendor, a final budget will be prepared in collaboration with the selected independent entity. Table 2 displays the proposed budget shell that will be used for submitting total costs for the Demonstration. Costs are broken out by staff, estimated hours, costs, and anticipated subcontractors. At this time, DHHS is working with its Actuarial vendor to secure their assistance in preparing all cost-related measures.

Table 2—Proposed Budget Template for NHHPP PAP			
	Year X (January 2016-2017)		
Staff Title	*Loaded Rate*	*Hours*	*Total*
Executive Director, Research & Analysis			
Project Director, Research & Analysis			
Project Director			
Project Manager			
Project Support			
Analyst			
Database Developer			
Reports Team			
Subtotal Direct and Indirect Costs			
Subcontractor - Statistician			
Subcontractor –Survey Vendor			
Subcontractor – Actuarial Vendor			
Annual Total			

As noted earlier, the costs presented in Table 2 will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning analyses and report generation. A final budget will be submitted once a final evaluation contractor has been selected.

5. APPENDIX A: EVALUATION COMPONENTS

PAP Waiver Goal[1]	Hypothesis Being Addressed[13]	Dimension of Access and/or Quality[14]
1. Continuity of coverage - For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks	1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage	Comparisons of provider networks
	2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers	Provider experience
2. Plan Variety - The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts	3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs	Evidence of improved access and quality across the continuum of coverage and related health outcomes
	4. The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts	Comparisons of provider networks over time.
3. Cost-effective Coverage - The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs	5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	7. The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS	Comparisons of provider networks
4. Uniform provider access - The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire	8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	9. Premium assistance beneficiaries will have equal or better access to preventive care services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided	Consumer satisfaction and other indicators of consumer experience
	11. Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes

[13] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf, Page 10 of 146. Last accessed on May 26, 2015.
[14] ibid, STC #69.1.a.

6. APPENDIX B: EVALUATION RESEARCH HYPOTHESES AND MEASURES

The 12 research hypotheses are grouped according to the four waiver goals delineated in Appendix A. The definitions presented below are generally quoted from Section II. Program Description and Objectives in the Special Terms and Conditions document.[15] Numbering of the individual research hypotheses from STC #69 is changed herein to correspond with the goals of the waiver shown in Appendix A.

Continuity of Coverage

Definition: For individuals whose incomes fluctuate, the NHHPP PAP Demonstration will permit continuity of health plans and provider networks. Individuals and families may receive coverage through the same health plans and seek treatment and services through the same providers regardless of whether their underlying coverage is financed by Medicaid or through the Marketplace. The State will evaluate whether individuals remain in the same QHP when Medicaid payment is terminated.

Hypothesis 1: ***Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage***

Gaps in insurance coverage decrease the potential for preventive care and, therefore, increase the potential for more expensive emergency and/or inpatient care. Due to the insurance premiums being paid by New Hampshire for eligible beneficiaries, any gaps in coverage should be for income level changes, moving out of State, aging out, death, incarceration, or other situation beyond the control of the State for ensuring continuous insurance coverage.

Measure 1-1	Continuity in Member Health Insurance Coverage
Definition:	The average number of gaps in insurance coverage
Technical Specifications:	The average number of gaps in insurance coverage per 100 members enrolled in PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[15] pa_termsandconditions.pdf

Measure 1-2	Continuity in Member Health Insurance Coverage
Definition:	The percentage of eligible members with gaps in insurance coverage
Technical Specifications:	The percentage of eligible members with gaps in insurance coverage, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 1-3	Patient Perspective on Continuity in Health Insurance Coverage
Definition:	Patient perspective on the continuity of health insurance coverage
Technical Specifications:	Eligible recipients will be surveyed to whether the members reported being without health insurance during the previous six months. "In the last six months, were you without health insurance at any time?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3[16]
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[16] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.

Hypothesis 2: ***Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers***

This two-part research hypothesis examines continuity of care within health plans and continuous access to providers associated with the member's health plan. For this research hypothesis, the providers are the groups of PCPs delivering care to the MCO's members. With the State paying for the beneficiaries' premiums, the intent is that members will see the same group of providers as least as commonly as the comparison group members.

Measure 2-1	Continuous Access to the Same Health Plan
Definition:	The percentage of eligible members with continuous access to the same health plan for the measurement year
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to the same health plan during the measurement period – one plan the entire time.
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 2-2	Patient Perspective on Continuity in Same Plan Coverage
Definition:	Patient perspective on continuous access to the same health care plan
Technical Specifications:	Eligible recipients will be surveyed to whether the members had continuous access to the same health care plan during the previous six months. "In the last six months, did you have to switch to a different health care plan?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 2-3	Patient Perspective on Continuous Access to Providers
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q6
Exclusion Criteria:	Subject to income level qualifications
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 2-4	Numbers of Medically Frail Self-Declarations
Definition:	The number of PAP members each year who self-declare as medically frail.
Technical Specifications:	The number of PAP members each year who self-declare as medically frail and leave the PAP population.
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	Annual, if the Demonstration is continued
Comparison Method(s):	None
National Benchmark:	None

Plan Variety

Definition: The NHHPP PAP Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace would afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and would increase the selection of plans for both Medicaid and Marketplace enrollees. The State will evaluate whether there is an increase in the number of available QHPs because of this potential for dual participation.

Hypothesis 3: ***Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs***

Beyond the continuity of insurance coverage previously addressed, this research hypothesis examines gaps in actual enrollment, the empirical continuity of care, and the

administrative costs of care. If the NHHPP PAP functions as designed, actual enrollment should be at least as continuous as for the beneficiaries in the comparison group, their continuity of care should be at least as good due to improved access, and the overall administrative costs should decrease through knowledge of premium costs weighed against the costs in the comparison group. Three measures will, in combination, be used to assess this research hypothesis.

Measure 3-1	Continuity in Plan Enrollment
Definition:	The average number of gaps in enrollment from any Medicaid plan
Technical Specifications:	The average number of gaps in enrollment of any kind from any Medicaid MCO or PAP plan per 100 enrollee years, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State Eligibility and Enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-2	Continuity in Plan Enrollment
Definition:	Percentage of eligible members with continuous health plan access
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to any Medicaid MCO or PAP health plan during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-3	Patient Perspective on Continuity of Care
Definition:	The cornerstone of continuity of care is in knowing one's PCP. For this reason, this portion of the research hypothesis is defined through whether the beneficiary has a personal doctor. For respondents, this item is defined as the proportional choice for "A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?" for responses 'Yes' or 'No'.
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q10
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 3-4	Members' Administrative Cost (Total Costs and Medical Costs Captured in Research Hypotheses 7-1 and 7-2)
Definition:	Administrative per member per month (PMPM) cost
Technical Specifications:	Annual administrative costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Hypothesis 4: ***The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees***

The idea supporting this research hypothesis is that market forces will take note of the influx of covered beneficiaries from the NHHPP PAP and will compete for market share. If the intended effect materializes, one benefit might be seamless transitions

between the traditional marketplace and the NHHPP PAP. Beneficiaries might see an advantage to belonging to plans offering both types of coverage, which then might increase the total number of plans competing for market share and the potential of dual participation.

Measure 4-1	Medicaid Care Management Carriers Offering QHPs in the Marketplace
Definition:	Desk audit for the number of Medicaid Care Management carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter for which dual participation could be an option
Technical Specifications:	Count of the number of Medicaid Care Management carriers offering QHPs in the Marketplace for which dual participation could be an option
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None
Measure 4-2	**QHPs in the Marketplace Offering Medicaid MCO Plans**
Definition:	Desk audit for the number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO Plans at the start of the waiver and annually thereafter
Technical Specifications:	Count of the number of QHPs in the Marketplace offering Medicaid MCO Plans
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None

Cost-effective Coverage

Definition: The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs. This, in turn, may result in coverage that achieves cost reductions in comparison to traditional Medicaid managed care coverage. The State will evaluate whether QHP coverage is cost-effective, looking at the entire NHHPP PAP Demonstration period and trends that emerge as it proceeds.

Hypothesis 5: ***Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services***

'Non-emergent use' is interpreted to mean that the service could have been appropriately delivered at a lower level, such as an urgent care clinic or at a PCP's office. One of the intended functions of the NHHPP PAP is to treat beneficiaries in the appropriate setting, which is often the PCP's office. The appropriate setting is

frequently less expensive and provides more local access than is found with non-emergent use of emergency room services.

Measure 5-1	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Eligibility Group
Definition:	Ambulatory emergency department visits for conditions potentially treatable in primary care per 1,000 member months by eligibility group
Technical Specifications:	AMBCARE.09 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf[17]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 6: ***Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions***

'Potentially preventable' in operationalized as ambulatory sensitive conditions, suggesting that more timely PCP care could have prevented the admission, rather than the admission being at too high a level of service, distinguishing the research hypothesis from research hypothesis 5. For example, emergency room use and/or hospitalization for complications from the flu are potentially preventable with influenza and pneumococcal immunizations, as appropriate.

Measure 6-1	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members
Definition:	Quarterly rate of inpatient hospital utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members
Technical Specifications:	HPP_INPASC.01 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[17] NH Medicaid Care Management Quality Oversight Health Plan Reporting Specifications – V2.3

Measure 6-2	Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members
Definition:	Quarterly rate of emergency department utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members
Technical Specifications:	Analogous to HPP_INPASC.01, but in the Emergency Department setting
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 7: ***The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS***

This research hypothesis examines the relative costs in a comparative format between the more traditional Medicaid managed care program comprised of the comparison group and the new beneficiary program comprised of the study group. By knowing the premiums in advance, the State can make comparisons with the costs for non-premium assistance beneficiaries to ensure that the new beneficiaries in the NHHPP PAP will not cost New Hampshire more than if the State had enrolled the expansion group in the more traditional Medicaid managed care program comprising the comparison group.[18]

Measure 7-1	Total Costs by Group
Definition:	Total per member per month (PMPM) cost
Technical Specifications:	Annual total costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

[18] Administrative costs are captured in research hypothesis 3.

Measure 7-2	Medical Costs by Group
Definition:	Annual per member per month (PMPM) cost
Technical Specifications:	Annual medical costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Uniform Provider Access

Definition: The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the NHHPP PAP Demonstration to determine if it is comparable to the access afforded to the general Medicaid managed care population in New Hampshire.

Hypothesis 8: ***Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services***

One critical feature of the NHHPP PAP is the contracted QHPs' ability to deliver appropriate access to care through the availability of primary care and specialty physicians and associated services. The research hypothesis examines the extent to which the NHHPP PAP is successful in maintaining the access and services found in the traditional Medicaid managed care program.

Measure 8-1	Medication Management for People with Asthma (MMA)[19]
Definition:	The percentage of members 19–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period
Technical Specifications:	State-modified HEDIS specifications[20]
Exclusion Criteria:	Diagnosis of emphysema, chronic obstructive pulmonary disease (COPD), obstructive chronic bronchitis, cystic fibrosis, acute respiratory failure, or members who have no asthma controller medications dispensed during the measurement year
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-2	Timeliness of Prenatal Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received prenatal care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.01 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

[19] The presented specifications are derived from the NCQA HEDIS 2015 Technical Specifications, Volume 2.
[20] HEDIS has some specifications that extend beyond the age range for the PAP program and are, therefore, State-modified to account for the age range difference.

Measure 8-3	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received postpartum care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.02 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-4	Patients' Perception of Ease of Getting Appointments with Specialists
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q18, CAHPS 5.0[21]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 8-5	Patients' Perception of Quick Access to Needed Care
Definition:	For respondents, a proportional choice for "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q4, CAHPS 5.0[22]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.

[21] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.
[22] Ibid.

Measure 8-5	Patients' Perception of Quick Access to Needed Care
National Benchmark:	Potentially CAHPS benchmarks

Hypothesis 9: *Premium assistance beneficiaries will have equal or better access to preventive care services*

Access to preventive care services is important for several reasons, as already seen through previous research hypotheses. Preventive services can help to maintain health and avoid more expensive emergency department use or hospitalization and are an important aspect of restraining the growth in the cost of providing health care. This research hypothesis evaluates access to preventive services.

Measure 9-1	Annual Access to (use of) Preventive/Ambulatory Health Services Adults by Age Group (i.e., 20-44, 45-64)
Definition:	The percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit, by age group
Technical Specifications:	HEDIS_AAP - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid managed care national rates

Measure 9-2	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)
Definition:	The percentage of discharges for members 19 years through 64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge
Technical Specifications:	HEDIS_FUH.01 - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-3	Annual Influenza Immunization, 19-64
Definition:	Flu vaccinations for adults ages 19 to 64: percentage of members 18 to 64 years of age who received an influenza vaccination between July 1 of the measurement year and the date on which the CAHPS 5.0 survey was completed
Technical Specifications:	NCQA
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-4:	Comprehensive Diabetes Care - Eye Exam
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who had an eye exam (retinal exam) performed
Technical Specifications:	HEDIS_CDC.05 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-5	Comprehensive Diabetes Care - Medical Attention for Nephropathy
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who received medical attention for nephropathy
Technical Specifications:	HEDIS_CDC.06 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-6	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Definition:	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-7	Mental Health Utilization - 1
Definition:	Mental health inpatient discharges
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-8	Mental Health Utilization - 2
Definition:	Mental health inpatient average length of stay
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-9	Diabetes Monitoring for People With Diabetes and Schizophrenia
Definition:	The percentage of members 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Hypothesis 10: ***Premium assistance beneficiaries will report equal or better satisfaction in the care provided***

Patient-centered health care is important for many reasons, not the least of which is the relationship between greater satisfaction and low costs of care. Patients tend to utilize preventive services and follow medical advice more often when they are satisfied with the care they receive. For that reason, this research hypothesis compares the satisfaction of the more traditional Medicaid managed care beneficiaries for their provided care with that of the NHHPP PAP beneficiaries.

Measure 10-1	Patients' Rating of Overall Health Care
Definition:	For respondents, a proportional choice for "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"
Technical Specifications:	CAHPS 5.0 specifications, Q8
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Measure 10-2	Patients' Rating the Health Plan
Definition:	For respondents, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"
Technical Specifications:	CAHPS 5.0 specifications, Q26
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Hypothesis 11: ***Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits***

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are important to maintain health, catch illness early, and prevent disease when possible. The medically recommended schedule for these services continues until the beneficiary's 21st birthday. This research hypothesis examines the extent to which premium assistance beneficiaries 19 and 20 years of age received these services compared with the comparison group.

Measure 11-1	EPSDT Screening
Definition:	Total eligible beneficiaries who received at least one initial or periodic Screen
Technical Specifications:	EPSDT.06 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 12: ***Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT)***

Non-emergency transportation services support timely access to care at the appropriate level of care, which helps to reduce cost, as discussed in previous research hypotheses. This research hypothesis seeks to ensure that premium assistance members maintain appropriate access to non-emergency transportation services.

Measure 12-1	NEMT Request Authorization Approval Rate by Mode of Transportation
Definition:	The percentage of NEMT requests authorized, of those requested during the measure data period, by mode of transportation (i.e., contracted transportation provider - non-wheelchair van, volunteer driver, member, public transportation, wheelchair van, other), for the eligible population
Technical Specifications:	NH specifications for HPP_NEMT.06 (including A-F)[23]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

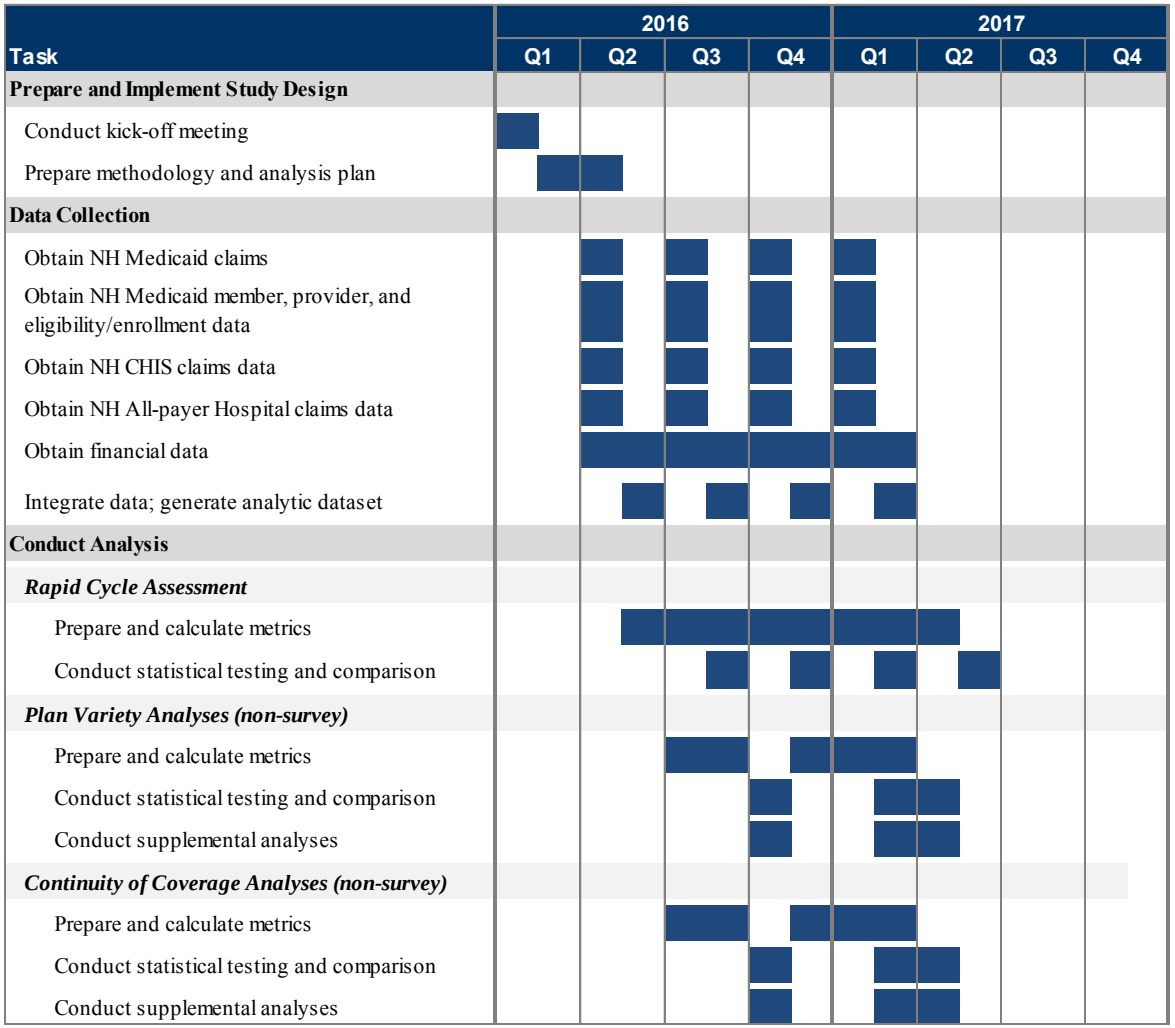
[23] New Hampshire Medicaid Quality Information System (MQIS), Specifications, Non-Emergent Transportation - NH Health Protection Program, Version 1.0, Published March 31, 2015.

7. APPENDIX C: EVALUATION TIMELINE

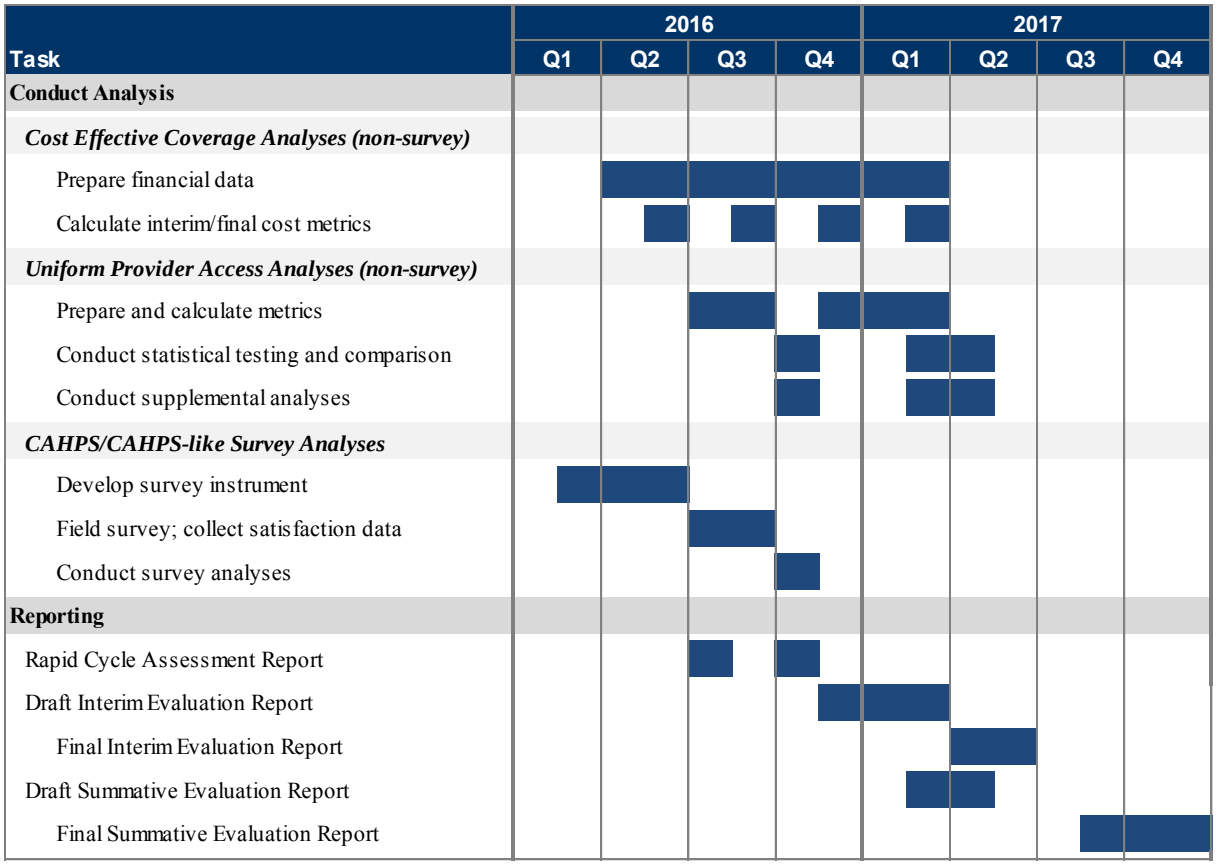
The following project timeline has been prepared for the Demonstration evaluation outlined in the preceding sections. This timeline should be considered preliminary and subject to change based upon approval of the Evaluation Design and implementation of the NHHPP PAP. A final detailed timeline will be developed upon selection of the Independent Entity tasked with conducting the evaluation.

Figure C- 1 outlines the proposed timeline and tasks for conducting the NHHPP PAP evaluation.

Figure C-1—NHHPP PAP Evaluation Project Timeline



APPENDIX F


Task
2016
2017
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Conduct Analysis
Cost Effective Coverage Analyses (non-survey)
Prepare financial data
Calculate interim/final cost metrics
Uniform Provider Access Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses
CAHPS/CAHPS-like Survey Analyses
Develop survey instrument
Field survey; collect satisfaction data
Conduct survey analyses
Reporting
Rapid Cycle Assessment Report
Draft Interim Evaluation Report
Final Interim Evaluation Report
Draft Summative Evaluation Report
Final Summative Evaluation Report

8. APPENDIX D: RAPID-CYCLE ASSESSMENT MEASURES

Continuity of Coverage (COC)

From a policy perspective in public health, continuity of coverage (COC) begins at the onset of available coverage (i.e., January 1, 2016, for NHHPP PAP members), rather than once coverage has been secured at a potentially later date. By definition, therefore, the 45,000 New Hampshire residents who are eligible for NHHPP PAP coverage before January 1, 2016,[24] and have NHHPP PAP coverage on January 1, 2016, have started continuity of coverage on time and do not have a *de facto* gap at the start of their available coverage.

Measure COC-1	Cumulative Initiation of Continuity in Member Health Insurance Coverage
Definition:	The cumulative number of NHHPP PAP beneficiaries with initiated coverage
Technical Specifications:	The total (i.e., sum) of the number of NHHPP PAP beneficiaries per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Measure COC-2	Proportional Initiation of Continuity in Member Health Insurance Coverage
Definition:	The proportion of the expected population of NHHPP PAP beneficiaries who have initiated coverage
Technical Specifications:	The ratio of the total (i.e., sum) of the number of NHHPP PAP beneficiaries to the 45,000 eligible people per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Plan Variety (PV)

One intended outcome of the NHHPP PAP is to motivate private insurers to create a dual participation in the Medicaid Care Management program and the Marketplace. This dual participation would afford Medicaid beneficiaries with seamless coverage

[24] New Hampshire Health Protection Program, Premium Assistance, Section 1115, Research and Demonstration Waiver, Final Application, November 7, 2014, Section 1, page 2

during times of transition, either across eligibility groups within Medicaid or from Medicaid to the Marketplace. From a rapid cycle perspective, the policy relevant outcome would be an increase in dual participation insurers.

Measure PV-1	Dual Participation Providers
Definition:	The number of dual participation providers
Technical Specifications:	The quarterly number of dual participation providers from the implementation of the potential for dual participation on November 1, 2015 through April 30, 2016 and quarterly thereafter
Data Source(s):	Administrative review
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Cost-effective Coverage (CEC)

One of the intended consequences of the premium assistance approach is to increase QHP enrollment and, therefore, result in greater economies of scale and competition among QHPs, lowering PMPM costs for Medicaid coverage.

Measure CEC-1	Total PMPM Total Cost - Quarterly
Definition:	Total per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly total costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-2	Medical PMPM Total Cost - Quarterly
Definition:	Medical per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly medical costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-3	Administrative PMPM Total Cost - Quarterly
Definition:	Administrative per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly administrative costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Uniform Provider Access (UPA)

One of the requirements for the NHHPP PAP is that it should provide equal or better access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration. One performance measure that has the potential not only to be available to rapid fire assessment, but could also touch on all three settings for uniform provider assess (i.e., primary, specialty, and behavioral health care services), is postpartum care. Regardless of how long the beneficiary has been enrolled in the NHHPP PAP, postpartum care is a valid measure of uniform provider access.

Measure UPA-1	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between each quarter who received timely and appropriate postpartum care
Technical Specifications:	HEDIS_PPC.02 – modified from NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf to be reported quarterly
Data Source(s):	All-payer Hospital, CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.